CONSENT FOR TREATMENT OF A MINOR

I, ____ , parent or legal guardian of _________________________, born _________________________ , do hereby Consent to any medical care and treatment determined by a physician or non-physician provider to be necessary for the welfare of my child while said child is under the care of the medical doctors and the staff of Southwest Dermatology Specialists. This consent shall remain in effect until the minor child turns 18, or until revoked in writing.

____ _________________ _________
Signature of Parent or Legal Guardian Relationship Date

________________________ _____________
Witness Date

Telephone Consent

1. Consent by telephone may be obtained when treatment is needed or desirable, and an adult patient is unable to give the consent in person.
2. Telephone consents require two witnesses.
3. Whenever possible, telephone consents should be followed up with a signature or fax.

Name	Relationship	Telephone	Date

Witness	Date	Witness	Date

Financially Responsible Party

Name:_____________________________________
Address: __________________________________
____
DOB: _____________________________________
Relationship: ______________________________

This person will be responsible for all payments not covered by insurance for the patient under the age of 18.