Dermatology Associates of Wisconsin

Minor Patient Treatment Authorization

Patient's name: _____ Patient's date of birth: _____/_____/_____
First Middle Initial Last

It is always desirable and recommended that a parent or legal guardian attend a minor child's appointment. **If a parent or legal guardian is not present at the time of a minor child's appointment, the child will be evaluated but no treatment will occur without this signed consent.**

Treatment authorized when parent / legal guardian not present:

- ☐ **Any recommended treatment**
- ☐ **Biopsy of area of concern**
- ☐ **Minor procedure(s)**
- ☐ **Prescribe medication**
- ☐ **Treatment of warts** (this may involve laser therapy, injections, cryotherapy or topical treatments)
- ☐ **Treatment of acne** (this may involve blood work, chemical peel, injections or laser therapy)

1. Insurance information:

- If you are not attending the appointment(s) with your minor child, please send with your child your insurance card (or copy of both sides of card), and any co-payment due along with this completed form.

Name of insured parent/guardian (cardholder): _____

Cardholder's date of birth: _____/_____/_____

Cardholder's social security # (not minor patient's): ___ ___ ___-___ ___-___ ___ ___ ___

Cardholder's relationship to patient: _____

2. <u>PAYMENT POLICY:</u>
The parent or legal guardian who signs this form will be responsible for all co-payments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees.

_____ _____ _____
Parent / Legal Guardian Signature Date Daytime phone #

In the event that you would like to mail or fax this form and a copy of insurance cards in advance, you may mail to 801 York St., Manitowoc, WI 54220 or fax to 1-866-698-6884