

**TREATMENT TO MINORS**

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

Many times parents/guardians find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I hereby grant Dr. Cynthia Rogers permission to treat my child when they arrive at the office unaccompanied or accompany by \_\_\_\_\_.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

**AUTHORIZATION TO CHARGE SERVICES TO MAJOR CREDIT CARD**

This agreement is required if you wish your child to be seen.

My minor child will be coming to the office for regular treatment of his/her dermatological condition; I authorize the above physician to charge to my major credit card (listed below) under the following circumstances:

**Initials**

\_\_\_\_\_ I understand that I am responsible for payment of my account at this time of service for deductibles, non-covered services, medically unnecessary services, copayments and insurance balances, should my primary insurance be with a company with which the physician(s) are contracted. If my insurance company is not one with which the physician is contracted, I am responsible for the entire amount at the time of service.

\_\_\_\_\_ For whatever reason, should my account fall into a 45 day or later (after the date of service) category, I authorize this office to generate charges to my major credit card for that unpaid balance without further permission or notice.

\_\_\_\_\_ A receipt for charges will be mailed to my address.

**VISA**       **MasterCard**     **Discover**

**Credit Card Number:** \_\_\_\_\_ **Exp Date:** \_\_\_\_\_

**Name as it appears on the credit card:** \_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Printed Name