LIFETIME DERMATOLOGY

Treatment to Minors

Many times parents 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. This agreement is effective for one year from the date below.

I hereby grant to LifeTime Dermatology permission to treat my child,

_____ when he/she arrives at the office unaccompanied.

_____ _____
Signature of Parent Date

Authorization to Charge Services to Major Credit Card

I understand that I am responsible for payment of my account at the time of service for deductibles, non-covered services, medically necessary services, co-payments and insurance balances, should my primary insurance be 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 ___Other

Credit Card #_____

Expiration Date _____/_____/_____

Name as it appears on the card _____

_____ _____
Signature Date