North Idaho Dermatology

Authorization to Treat a Minor

All patients of minor age (under 18) must have authorization and consent provided by a parent or legal guardian prior to receiving evaluation and/or treatment.

I hereby authorize Dr. Stephen Craig and/or other such associates as may be selected by the attending doctor to examine, evaluate, manage and perform procedures on my minor child or ward ____________________________________ *(minor name)*. My signature below attests that I am the parent or legal guardians of the minor named, and have the authority to provide this authorization.

______________________________   _____________
Signature of parent/legal guardian   Date

____
Printed name of parent/legal guardian

Authorization to treat unaccompanied minor

Sometimes parents find themselves unable to accompany their minor child to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I hereby authorize my child to be seen unaccompanied by his/her parent or legal guardian at North Idaho Dermatology for examination and/or treatment. I authorize Dr. Stephen Craig and/or other such associates as may be selected by the attending doctor to examine, evaluate, manage and perform procedures on my minor child and to in all other ways proceed with their recommended treatment.

Full legal name of minor child: ____

(Please initial all that apply)

_____ I have completed a Patient Information Form including a list of the child's know allergies.

_____ I understand that I am responsible for payment of my account at the time of service for deductibles, non-covered services, medically unnecessary services, co-payments, and balances after insurance has paid.

_____ My minor child will be coming to the office for examination and/or treatment, and I authorize the provider to charge my credit card listed below.

_____ I would like a receipt for charges mailed to my address.

_____ I would like my child to bring my receipt for charges home with him/her.