North Idaho
DERMATOLOGY

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Authorization to Treat a Minor

All patients of minor age (under l8) must have authorization and consent provided by a parent or legal guardian prior to receiving evaluation and /or treatment.

I hereby authorize Dr. Benjamin Ringger 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 or legal guardian

_____

Date:

_____

Printed name of parent or 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. Benjamin Ringger/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 known allergies

☐ I understand that I am responsible for payment of my account at the time ofservice 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 or charges home with him/her.