ALLIANCE DERMATOLOGY ASSOCIATES

Princeton, NJ• Newtown, PA
www.alliancedermatologyassociates.com
p. (609) 799-1600 f. (267) 358-5166

PERMISSION TO ACCOMPANY A MINOR

I, _____, give permission to temporary guardians listed below to
(Name of Parent(s)/Guardian)
accompany my child, _____, and authorize treatment for my child in
(Name of Child)
accordance with the office policy of Alliance Dermatology Associates. This includes bringing the child into the office of Alliance Dermatology Associates, providing a history of present illness, disclosing protected health information, witnessing any physical exam and procedure completed by the provider. This adult has the responsibility to relay any diagnosis, treatment plan or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone. I agree to be financially responsible for all copays and coinsurance.

#1 Temporary Guardian Information

Full Name: _____ Relationship: _____

Phone: _____Address: _____

This authorization is effective from: _____ to _____
(effective date) (end date)
_____ until revoked in writing by the undersigned
(effective date)

#2 Temporary Guardian Information

Full Name: _____ Relationship: _____

Phone: _____Address: _____

This authorization is effective from: _____ to _____
(effective date) (end date)
_____ until revoked in writing by the undersigned
(effective date)

Child's Health Information

Current prescribed or over-the-counter medications: _____

_____

_____

Allergies, illnesses or other comments: _____

_____

Emergency Contact Information for Parents/Guardians:

Where/how can you be contacted in case of emergency? _____

Phone: _____Comments:_____

Health Insurance Information ❒ No change since last visit *(skip to next section)*

Insurance Company:_____ Policy Holder: _____

ID Number: _____ Group Number: _____

Effective Date: _____ Copay: _____

Parent/Legal Guardian's Signature_____**Date**_____

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CONSENT TO TREAT A MINOR

I _____ give permission to my child _____
(Name of guardian) (Name of child age 16-18 years)

to attend his/her illness appointment alone without my presence and authorize treatment for my child in accordance with the office policy of Alliance Dermatology Associates. This includes providing a history of present illness, disclosure of protected health information, and responsibility for relaying any diagnosis, treatment plan, or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone. I agree to be financially responsible for all copays and coinsurance. This authorization is effective on: _____ and
(Today's Date)

expires _____.
(Date Authorization is No Longer Valid)

Child's Health Information
Current prescribed or over-the-counter medications:_____

_____

_____

Allergies, illnesses or other comments: _____

_____

_____

Emergency Contact Information for Parents/Guardians:
Where/how can you be contacted in case of emergency? _____

Phone: _____

Comments:_____

_____

Health Insurance Information ❒ No change since last visit *(skip to next section)*

Insurance Company:_____Policy Holder: _____

ID Number: _____Group Number: _____

Effective Date: _____Copay: _____

Parent/Legal Guardian's Signature: _____

Date:_____