CONSENT TO TREAT MINOR PATIENT

I, _____, am the legal guardian/parent
Print Full Name of Parent or Legal Guardian
of _____, currently a minor, whose birth
Print Full Name of Minor Patient
date is _____ / _____ / _____. authorize Billings Dermatology & Aesthetics and its medical personnel to provide medical and/or surgical health care to my son/daughter, including, but not limited to, diagnostic examinations, and necessary medical treatment including surgical procedures for the treatment of _____.
List condition to be treated

This authorization shall remain in effect until my child turns eighteen years of age. I further understand, once my child reaches the age of majority, my consent for treatment is no longer required.
Furthermore, I understand that it is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient's portion at the time services are rendered. By signing this, I acknowledge that I have read and understand this consent.

_____ _____
Parent/Legal Guardian Signature Date

UNACCOMPANIED MINOR* (for patients age 16 and older)

I, _____, am the legal guardian/parent
Print Full Name of Parent or Legal Guardian
of _____, currently a minor, whose birth
Print Full Name of Minor Patient
date is _____ / _____ / _____. hereby grant Billings Dermatology & Aesthetics and its medical personnel permission to treat the minor listed above in my absence.

_____ _____
Parent/Legal Guardian Signature Date

Emergency Phone Contact: _____

***OUR OFFICE POLICY REQUIRES PATIENTS UNDER THE AGE OF 16 TO BE ACCOMPANIED BY AN ADULT**

Please return this form via mail or fax to:
Billings Dermatology & Aesthetics
2294 Grant Rd
Billings MT 59102
Fax: 406.294.9520 Phone: 409.294.9515