



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.

I hereby grant Alpine Dermatology, PC permission to treat my child when they arrive at the office unaccompanied.

My minor child will be coming unaccompanied to the office for regular treatment of his dermatological condition. I authorize the above office to charge my major credit card (listed below) under the following circumstances. (This agreement is required if you wish your unaccompanied child to be seen).

Services rendered to my minor child _____

for the treatment of _____ to an amount not to exceed \$ _____

without further permission from or notice to me.

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 all services rendered at the time of service. If I make a request, Dr. Eberting will provide me with a billing form to send to my insurance company.

A receipt for charges will be mailed to my address: _____

Visa MasterCard

Credit Card# _____

Exp. Date: _____ Name on Card: _____

Today's Date: _____ Signature: _____