Dermatology Specialists of Naples

TREATMENT TO MINORS

Patient Name: _____

Many times, parents/guardians find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you be unable to accompany your child.

I hereby authorize Dr. Cynthia Strohmeyer and / or Assistants permission to treat my child when they arrive at the office unaccompanied or accompanied by

_____.
(Grandparent, Aunt, Uncle, etc.)

This agreement is required if you wish your unaccompanied child to be seen.

_____ ___/___/___
Signature of Parent/Legal Guardian Date

My minor child will be coming to the office for regular treatment for his/her dermatological conditions unaccompanied, I authorize Dr. Cynthia Strohmeyer and / or Assistants to collect payment by chosen method: cash, check, or credit card. *(Please note we do not keep credit cards on file.)*

Initials

_____ I understand that I am responsible for payment of the account at the time of service for deductibles, non-covered services, medically unnecessary services and copayments.

_____ A receipt for charges will be mailed to your address.

_____ ___/___/___
Signature of Parent/Legal Guardian Date