Skin Spectrum, P.C.
6127 N. La Cholla Blvd., Ste 101
Tucson, AZ 85741
(520)797-8885

Treatment to Minors

Consent to treat patients under 18 years of age

Name of minor patient:___________________________________

This form has been prepared for your convenience should you at some time be unable to accompany your child or young adult, to their dermatological appointment.

I hereby grant to Skin Spectrum, and its medical providers, permission to treat my child when he/she arrives at the office unaccompanied.

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Signature of Parent: **Date:**

Authorization to charge services to credit card.

Initials

________ My minor child will be coming to the office for regular treatment of his/her dermatological condition unaccompanied; I Authorize Skin Spectrum to treat my son/daughter and charge my credit card for services performed. I authorize my credit card information to be kept on file.

_______ Please mail me a receipt for services.

☐ VISA ☐ Master Card ☐ American Express ☐ Discover

Credit Card#:_________________________ Expiration Date: __/__/__

Name that appears on the credit card:____

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Card holder signature: **Date:**