PROVIDENCE DERMATOLOGY
General, Surgical, Cosmetic

CONSENT TO TREAT A MINOR WITHOUT A PARENT/GUARDIAN PRESENT

Minor Child's Name: _____ **Date of Birth:** _____

I, hereby grant **PROVIDENCE DERMATOLOGY**; Dr. Travis S. James DO, MHA, FAAD and its medical personnel consent to any and all medical care & treatment determined to be necessary for the welfare of my child while under their care. This includes but is not limited to wart treatments, skin checks, acne treatments, and biopsies. I also agree to be financially responsible for payment of all charges in connection with the care and treatment rendered in my absence.

Unless revoked sooner in writing, this consent remains in effect until: *(please select one)*

☐ minor turns 18 years old

☐ until the _____ of _____, 20_____
day month year

Please initial <u>both</u> of the following:

[_____] I am authorizing the above minor to seek & consent to treatment with no adult or guardian present.

[_____] I acknowledge that I am responsible for payment of all charges in connection with the care & treatment rendered in my absence.

Should the provider need to reach me during the visit, I will be available at the following phone number: (_____) _____ - _____.

Printed Name of Parent/Guardian_____

Signature of Parent/Guardian: _____**Date:** _____

Office Witness: _____