CLEAR
Dermatology & Aesthetics Center

CONSENT TO TREAT A MINOR

Many times parents find themselves unable to accompany their teen or young adult to appointments, or choose not to be in the treatment room with their minor. This form has been prepared for your convenience should you at some time be unable to accompany your child or find it necessary to have a friend or other family member accompany your child to his/her visit. By signing this form you are giving permission for Clear Dermatology and Aesthetics Center to evaluate and treat your child. Please understand it is our policy to collect copay and any payment due before services are rendered.

Effective immediately, I hereby grant CLEAR DERMATOLOGY AND AESTHETICS

CENTER permission to treat my child, _____, _____.
(Print Patient Name) (Date of Birth)

I grant permission for the following individuals to accompany my child to appointments at Clear Dermatology and Aesthetics Center.

Name Relationship to Minor Contact Phone Number

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ **Print Name of Parent/Guardian**

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

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