MT. PLEASANT
DERMATOLOGY

Authorization to Treat Minor

I authorize Dr. _____, to examine, diagnose, and treat my child, _____, at his/her discretion in the event that I am unable to accompany my child on subsequent office visits. I am financially responsible for the treatment of this patient and will remit payment to **Mt. Pleasant Dermatology** with the visit.

_____ _____

Signature/Relationship Telephone Number

_____

Date

**For your convenience, Mt Pleasant Dermatology accepts all major credit cards. Upon check-out the patient may call the responsible party to obtain credit card information or one can be stored on your child's account. A check may be sent with the patient to remit payment.