AESTHETIC SURGERY ASSOCIATES

Consent to Treat Minor Children

I, _____, give permission to _____ to accompany
(Name of Parent/Legal Guardian) (Name of Adult to be Accompanying Minor)
my child _____ and authorize treatment for my child in accordance with the office
(Minor's Name and Date of Birth)
policy of Aesthetic Surgery Associates. This includes bringing the child into the office, providing a history of present illness, disclosing protected health information, and witnessing any physical exam and treatment completed by the provider. This adult has the responsibility to relay any diagnosis, treatment plan or prescription(s) to the parent or legal guardian mentioned above. I understand that Aesthetic Surgery Associates will not treat a minor that is not accompanied by an adult.

This authorization will be effective one year from today, _____, unless terminated in writing before that
(Date)
date.

Child's Health Information

****Current health insurance card and copay *(if applicable)* MUST be brought to the visit, even if no change.**

Allergies, illnesses, changes to medical history since last visit, new medications or other comments:

_____

_____

_____

_____

Temporary Guardian Information

Name: _____ Phone Number: _____

_____ _____

Signature of Temporary Guardian Date

According to Pennsylvania Statute, this authorization shall be signed by the parent or legal guardian in the presence of and along with the signatures of **two** witnesses who are at least 18 years of age:

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Printed Name and Signature of Witness #1 Date

_____ _____

Printed Name and Signature of Witness #2 Date