AESTHETIC SURGERY ASSOCIATES

Consent to Treat Minor Patient- Without Parent/Legal Guardian Present

By law, any child under the age of 18 years old cannot receive medical care without consent from a parent or legal guardian.

Minor's name: _____DOB: _____

LIMITATIONS:
Identify any specific limitations on the kinds of medical services for which this authorization is given. (If none, state "none") _____

_____

____ Check here if you wish to give consent for the minor to receive medical care **without an accompanying adult.** This consent may only apply **to minors age 16 and older**.

This consent shall be in effect for: □Date_____ (only)
□Indefinitely, until revoked by written communication

AUTHORIZATION:
I (parent/legal guardian name) _____ request and authorize Aesthetic Surgery Associates Plastic Surgery & Dermatology and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am aware that a current health insurance card and copay *(if applicable)* MUST be brought to the visit, even if no change.

I have the legal right to preauthorize Aesthetic Surgery Associates/ASA Dermatology to deliver routine medical treatment and services to my child. Routine medical care may include, but is not limited to: medical evaluation, physical exam, and treatment (i.e. topical and oral medications, simple procedures such as liquid nitrogen, cantharone and biopsies)
I have read, understand, and give my consent as stipulated above.

_____

Parent/Legal Guardian (please print) **Relationship**

Parent/Legal Guardian Signature **Date**