Alpine Dermatology Associates, P.L.L.C.
1785 Kipling
Lakewood, CO 80215
303-935-4681

TREATMENT TO MINORS

Many times parents find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I (we) hereby grant Alpine Dermatology Associates permission to treat my (our) child(ren) listed below when they arrive at the office unaccompanied:

PLEASE PRINT

Name: _____

DOB: _____

Name: _____

DOB: _____

Name: _____

DOB: _____

Please try to contact me (us) regarding health care of my (our) child(ren) at the following phone number(s):

Parent's Name: _____

Phone (office/home/cell): _____

Other (relationship): _____

Phone (office/home/cell): _____

Signature: _____

Please Print Name and Relationship: _____

Date _____

NOTE: If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardianship with non-parent, etc.), please explain in the space below with your signature, printed name, and phone number, where you can be contacted:

_____

_____

_____

_____

_____

AUTHORIZATION TO CHARGE SERVICES TO MAJOR CREDIT CARD

This agreement is required if you wish your unaccompanied child to be seen.

My minor child will be coming to the office for regular treatment of his/her dermatological condition unaccompanied; I authorize Alpine Dermatology Associates to charge my major credit card (listed below) under the following circumstances:

Initials

_____ I understand that I am responsible for payment of my account at the time of service for deductibles, non-covered services, medically unnecessary services, co-payments, and insurance balances, should my primary insurance be with a company with which the physician(s) are contracted. If my insurance company is not one with which the physician is contracted, I am responsible for the entire amount at the time of service.

_____ For what ever reason, should my account fall into a 45 day or later (after the date of service) category, I authorize this office to generate charges to my major credit card for that unpaid balance without further permission or notice.

_____ A receipt for charges will be mailed to my address.

____VISA ____MasterCard

Credit Card #: _____ Expiration Date: ____/____/____

Name as it appears on the credit card: _____

_____ _____

Signature Date