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Piedmont HealthCare
Mooresville Dermatology

Dr. Naomi Simon
Dr. Michael Redmond
Kristin Prochaska, PA-C

CONSENT TO TREAT MINOR PATIENT

I, _____ am the parent/legal guardian of _____,
Print Full Name of Parent/Legal Guardian — Print Full Name of Minor Patient

Whose date of birth is: _____/_____/_____. As such, I hereby authorize the following individual(s) to accompany my child to his/her appointments if/when I am unable to accompany him/her myself:

NAME	RELATIONSHIP TO PATIENT
_____	_____
_____	_____
_____	_____

I understand that this authorization shall remain in effect until my child turns eighteen years of age or until I revise or revoke it. I further understand that once my child reaches the age of majority, my consent for treatment is no longer required and I will ONLY be granted access to information regarding my child's care if he/she authorizes the release of such information to me. I further understand that it is the policy of Piedmont HealthCare and this office that the adult presenting the child for treatment is responsible for payment of the patient's copayment/coinsurance/deductible at the time services are rendered. By signing this authorization, I acknowledge that I have read and understand this content.

_____ _____
Parent/Legal Guardian Signature — Date

UNACCOMPANIED MINOR* (FOR PATIENTS AGE 16 AND OLDER)

I, _____ am the parent/legal guardian of _____,
Print Full Name of Parent/Legal Guardian — Print Full Name of Minor Patient

Whose date of birth is: _____/_____/_____. As such, I hereby authorize Mooresville Dermatology Center and its medical personnel to treat my child in my absence. I understand that my child is responsible for payment of any copayment/coinsurance/deductible amount at the time services are rendered.

_____ _____
Parent/Legal Guardian Signature — Date

Emergency Contact: _____ _____
Name — Telephone Number

***Our office requires patients under the age of 16 to be accompanied by an adult.**