Anne Arundel DERMATOLOGY
and Affiliate Practices

To Parents and Guardians of Minor Children:

The providers and staff of Anne Arundel Dermatology, P.C. ("AAD") place great emphasis on the health and well-being of each and every patient that comes to our offices. We appreciate that you have entrusted us to provide dermatology services to your minor child and we look forward to working with you to ensure that your child receives the best health care possible.

Please see the Consent to Treat a Minor form that, once completed by a parent or legal guardian, will be placed in your child's medical record for use as necessary. This form will allow us to provide routine and emergency medical treatment for your minor child as necessary. This consent form will remain in effect until revoked in writing. You may request this form from any member of our office staff.

As a general rule, we require the consent of a parent or legal guardian in order to provide health care services to a minor child (someone under the age of 18). You will be asked to sign the authorization for treatment on or before the first visit, and to come to the office for as many visits as possible. The authorization allows you to approve: a) a course of therapy for your child with your participation and consent; b) that other responsible adults that you name may bring your child to the office; c) that we treat your adolescent child when s/he comes to the office unaccompanied by a responsible adult; and, d) that we can help in a health emergency. If your minor child presents to the office unaccompanied, we will check that you have signed the authorization to treat your adolescent child in your absence, and will reschedule if we do not have your written approval. If the minor presents in the company of an adult other than a parent or legal guardian, we will check that they are the persons named in the authorization; or that you have otherwise authorized in writing your consent.

Adults, other than the parent or legal guardian who accompany a minor child to an appointment and are authorized by the Consent to Treat a Minor on record, will be asked to present a photo ID upon checking the patient in for the appointment. If consent documentation or photo identification is missing, the appointment will be rescheduled.

By law, minors have the right to consent to health care under specific circumstances. For the purposes of dermatology care, a minor may consent to care if s/he is married, or is self-supporting regardless of income. A minor who is also a parent may consent to treatment for his or her child, even if the parent is under age 18.

It is the philosophy of this medical practice to encourage minor patients to include a parent, guardian or other trusted adult in all aspects of their health care. If you have questions regarding any of this information, please contact your child's treating physician.

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Consent to Treat a Minor

Patient name: _____ Date of birth: _____

Patient name: _____ Date of birth: _____

Patient name: _____ Date of birth: _____

I, the undersigned, parent(s) or legal guardian of the above named minor patient(s), confirm that there are no court orders now in effect that would prohibit me from conferring the power to consent upon another person. I hereby authorize the physicians, physician assistants, and nurse practitioners, at any Anne Arundel Dermatology, P.C. ("AAD") practice site to provide healthcare services as outlined in the General Agreement to Outpatient Services, including assessment, planning, diagnosis and treatment approved by a supervising physician who is licensed to practice in the state where the minor's healthcare service is being rendered.

In an emergency, it is understood that authorization is granted to the physicians, physician assistants, and nurse practitioners at AAD to provide emergency care, treatment, and/ or hospital referral which is deemed necessary in the exercise of his or her best judgment.

Consent to Treat a Minor Child accompanied by an adult other than the child's parent or legal guardian.

I, the parent or legal guardian of the patient named above, do hereby authorize the physicians at AAD to perform medical treatment as per the statements above when accompanied by either of the following named adult persons over the age of 18:

Adult's name: _____ Relationship to the child: _____
(Print Name) (Grandparent, Aunt, Uncle, Sister, Brother, Family Friend)

Address: _____

Adult's name: _____ Relationship to the child: _____
(Print Name) (Grandparent, Aunt, Uncle, Sister, Brother, Family Friend)

Address: _____

☐ I authorize my adolescent child to be treated at the office visit(s) if I am unable to attend.

This authorization is valid:

☐ For any and all medical treatment.
☐ For today only.
☐ For this specific problem(s) or a specific date range. Please specify:

This consent will be valid until revoked in writing by me from the date signed unless otherwise specified in writing.

Parent or legal guardian: (Print Name) _____ Date: _____ /____ / ____

Parent or legal guardian signature: _____

Witness: (Print Name) _____ Signature: _____

Witness: (Print Name) _____ Signature: _____