Authorization to Treat Minor Patients

Dear Parent or Guardian,

Dermatology Specialists of Omaha, LLC strives to provide the highest quality of care to all of its patients.

We realize there are times when busy parents are not able to bring their minor children for their appointments and choose a relative or other designated person to bring them in. In order for us to evaluate and treat a minor child without the parent or legal guardian, we will need to have a signed authorization to do so.

All patients that are 18 years of age and younger who come without their parent or legal guardian, will need sign the Authorization to Treat Minor Patients. Legal Guardians will need to provide court documents to prove guardianship. If we don't have the signed authorization, the parent will need to accompany the minor.

We appreciate you choosing Dermatology Specialists of Omaha, LLC for you and your families dermatological care. If you have questions, please feel free to call me at 402-763-1516.

Kind regards,

Teresa Dilts

Teresa Dilts
Administrator

Consent Forms

Place Patient Label Here

Dermatology Specialists of Omaha

Authorization To Treat Minor Patient

I, _____ parent or legal guardian of

_____

(Patient Name) (Date of Birth)

authorize Dermatology Specialists of Omaha, LLC to evaluate and treat my child for:

☐ _____ specify condition *(new condition will require new authorization).*

☐ Or any common skin conditions such as acne, warts, rash, eczema, or psoriasis (*including blood tests).*

This authorization is in effect for twelve months from the date of my signature. I understand that if the condition does not improve, I may be required to attend the appointments to discuss personally my child's condition with the provider. I also understand I will be required to sign a separate consent for biopsies, excisions and any other surgical procedure. If I am not available to give consent for additional treatments, my child may be rescheduled when I am available to give consent.

I also give the following individuals permission to bring my child to their appointment:

1. _____
(Name) (Relationship)

2. _____
(Name) (Relationship)

☐ I decline to authorize treatment to minor child and will be present at all scheduled appointments.

_____ _____

Signature of Parent or Legal Guardian Date