Demographics

DERMATOLOGY SPECIALISTS OF OMAHA
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Authorization To Treat Minor Patient

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

I, _____ parent or legal guardian of _____ 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 condition such as acne, warts, rash, eczema, or psoriasis *(including blood tests).*

Please initial next to each line below, to confirm your understanding of each statement.

_____ A parent/guardian MUST attend the first appointment of a new minor patient.

_____ Treatment, including prescriptions and procedures, of a minor (age 18 and under) without a legal guardian is at the discretion of the doctor or PA.

_____ The doctor or PA may request a return visit with a parent or legal guardian present.

_____ All initial and subsequent visits are subject to charges as set by your insurance.

_____ A separate consent will be necessary for any biopsies, excisions or other surgical procedures. A parent or guardian MUST be present for these appointments.

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

1. _____
(Name) (Relationship)

2. _____
(Name) (Relationship)

3. _____
(Name) (Relationship)

x _____
Signature of Parent or Legal Guardian **Date**

Follow My Health Authorized User Access

❑ I am the parent of a Minor patient aged 19 or younger and possess their birth certificate
❑ I have legal paperwork for POA/Guardian/Adoption/Ward of the State or County for this patient

Authorized User Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Authorized User DOB: _____ Relationship to Patient: _____
MM/DD/YYYY

I hereby authorize DSO to use/disclose individually identifiable health information to the Follow My Health patient portal

x _____
Signature of Parent or Legal Guardian **Date**