OAKVIEW
DERMATOLOGY

CONSENT TO TREAT MINOR PATIENT-WITHOUT PARENT/LEGAL GUARDIAN PRESENT

Name of Child/Minor _____ **Date of Birth** _____

Appointment Date _____

AUTHORIZATION:

I authorize **Oakview Dermatology, LLC** and any provider/employee to provide medical care for this patient for whom I am the legal guardian. This consent includes contact and discussion with other health care professionals, such as my primary care physician or specialists for my care and treatment.

In the event that pathology and lab work is needed I authorize **Oakview Dermatology, LLC** and **PathGroup** (Oakview's in-office lab service) to perform the service necessary for treatment.

I also authorize **Oakview Dermatology, LLC** to bill my insurance company for services provided to the patient named above unless they are deemed cosmetic. I assign all payments for these services to the practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan. I further understand that my contract with my insurance may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

I have read, understand and give my consent as stipulated above.

Parents or Guardian's Name _____ **Phone Number** _____

Parent or Guardian's Signature _____ **Today's Date** _____

Billing Office:

2111 East State Street, Athens, Ohio 45701 P: 740-566-4621 • F: 740-566-4622

Offices In:

Athens, OH	Belpre, OH	Chillicothe, OH	Fort Mill, SC
Gahanna, OH	Lancaster, OH	Rock Hill, SC	Springfield, OH