Consent for Treatment of a Minor

I authorize a designated Provider and/or Assistant of Desert Dermatology PLLC to examine, treat and/or perform all

medical and/or minor surgical procedures, which may be deemed necessary, with or without the presence of a Legal Guardian.

I further understand that I am responsible for the costs of all medical treatments and/or procedures, whether or

not such medical treatments and/or procedures are covered by insurance. I agree to pay Desert Dermatology PLLC for any and all costs incurred by the named minor patient.

Patient's Last Name: _____ First Name: _____ M.I. _____

DOB: _____ / _____ / _____

(Month) (Day) (Year)

Guarantor's Last Name: _____ First Name: _____ M.I. _____

Relationship to Patient: _____

Guarantor's Signature _____ Date: _____

This consent is in effect until cancelled by the patient or person authorized to consent for the patient.