LAKE SHORE DERMATOLOGY

Kavitha Gandhi, M.D.

T 847.680.7100
F 847.775.0704

TREATMENT TO MINORS

Many times parents find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I hereby grant to Lake Shore Dermatology permission to treat my child when he/she arrives at the office unaccompanied.

_____ _____
Patient Name Patient Date of Birth

_____ _____
Parent or Guardian Name Parent Phone Number
(at which we may reach you during appointment)

_____ _____
Signature of Parent or Guardian Date

AUTHORIZATION TO CHARGE SERVICES TO MAJOR CREDIT CARD

This agreement is required if you wish your unaccompanied child to be seen.

My minor child will be coming to the office for regular treatment of his/her dermatological condition unaccompanied and I authorize charges to my major credit card (listed below) under the following circumstances:

Initials
_____I understand that I am responsible for payment of my account at the time of service for deductibles, non covered services, medically unnecessary services, copayments and insurance balances, should my primary insurance be with a company with which the physician is contracted. If my insurance company is not one with which the physician is contracted, I am responsible for the entire amount at the time of service.

_____A receipt for charges will be sent home with your child.

❑ Visa ❑ Mastercard 3-digit security code _____
(Found on the back of card)

Credit card #_____ Expiration Date_____

Name as it appears on the card_____

_____ _____
Signature of Parent Date