NORTHEAST DERMATOLOGY
925 North Hamilton Road, Suite 100 Gahanna, OH 43230
Ph: (614) 473-9519 Fax: (614) 473-9543

PARENTAL CONSENT FORM

Date: _____

Minor Patient Name:
_____

Patient Date of Birth_____

I, _____, the parent or guardian of the above minor patient authorize NORTHEAST DERMATOLOGY, its physicians and staff permission to treat my minor child.

This consent is limited to office visits or cryosurgery procedures but does not include any surgical procedures as it is understood that I must be present during any such surgical procedure, including but not limited to, a biopsy or excision performed upon my minor child. I further agree that NORTHEAST DERMATOLOGY will not telephone me before or after any office visit by my minor to discuss treatments provided or medications prescribed when I do not accompany my minor child. I understand that all payments including copayments and deductibles are due at the time of service.

_____ _____

Parent/ Guardian Signature Witness Signature

_____ _____

Printed Name of Parent / Guardian Printed Name of Witness