CONSENT FOR TREATMENT OF MINOR CHILD

I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guaranties have been made to me as to the result of treatment or examinations performed. I hereby authorize Liberty Dermatology, P.A., Dr. Kien Tran, MD, PhD, and whoever may be employed or assistant in administration, to administer care as is deemed necessary to the child below:

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

I warrant that I am the party responsible for making medical decisions for the child represented in this medical record. I acknowledge that payment is due at the time of service. I assume financial responsibility for any and all healthcare services provided to this patient. I understand that the provider of service will not get involved in matters involving third party personal billing whether result of custody, court order, or personal circumstances. The parent/guardian who is accompanying the child to the visit is responsible for any payment due at the time services are rendered and any amount not covered by insurance other amounts determined by the insurance company to be the patient's or guardian's responsibility and any collection/attorney fees incurred in collecting that balance.

Please check one:

[ ] I also authorize Liberty Dermatology, P.A., Dr. Kien Tran, MD, PhD, and whoever may be employed or assistant in administration, to administer care as is deemed necessary to the child above **in case the child or teenager arrives or drives to the clinic unaccompanied.** I am aware that I am financially responsible for my child in regards to payment for services at the time of treatment and will either leave information for a form of payment with the clinic or the child will carry a form of payment with them if they arrive unaccompanied.

[ ] I do not authorize and do not wish my child to be treated if the child arrives at my clinic for a routine visit (not an emergency) without me present or an authorized representative (below). (If you check this and the child arrives or drives by themselves to the clinic, we will NOT be able to treat them unless it is an emergency.)

MEDICAL RELEASE SPECIAL AUTHORIZATION

I authorize the following name person(s) to authorize (medical) treatment for my child by Liberty Dermatology, PA. and to have access to my child's health information. I understand that I am responsible for services rendered for treatment and payments authorized by my personal representatives. If I choose to terminate the authorization of this form, I understand I must do so in writing. Please list anyone who has the legal authority to bring the child to the clinic:

NAME OF PERSON BRINGING CHILD	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
_____	_____	_____

I have read and agree with the above information:

Signed by: _____ **Date:** _____

Print Name:_____ **Relationship to Child:** _____