Northeast Dermatology and Cosmetic Surgery Center
925 N. Hamilton Road, Suite 100 Gahanna, OH 43230
Phone (614) 473-9519 Fax (614) 626-7774

PARENTAL CONSENT FORM

Date:_____

Minor Patient Name:_____ 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. I agree that Northeast Dermatology will not telephone me before or after any office visit by my minor to discuss treatments provided or medication prescribed when I do not accompany my minor child. I understand that all payments including copayments and deductibles are due at time of service.

_____ I give permission for Evaluation and Management visits only. (no procedures)

_____ I give permission for Evaluation and Management visits as well as simple procedures. Including but not limited to, Liquid Nitrogen (LN2), Shave Biopsy or Shave Removal, Injection of Medication (Lidocaine, Kenalog, etc)

_____ _____

Parent/Guardian Signature Witness Signature

_____ _____

Printed Name of Parent/Guardian Printed Name of Witness

Consent is valid for 1 year. This consent form expires on _____/_____/_____