JOHNSON DERMATOLOGY
3310 W. MAIN ST., STE 115
ST. CHARLES, IL 60175
(630)232-2885
(630)232-9936(fax)

TREATMENT TO MINORS CONSENT FORM

Patient Name: _____ DOB: _____

Minors 16 or 17 years old, must have a Parent/Legal guardian present for an initial office visit or they will be asked to reschedule their appointment. If the patient is 16 or 17 years old, they can be seen for follow up appointments without a Parent/Legal guardian only if Parent/Legal guardian fills out and signs this consent form authorizing this office to provide treatment to their teen.

I hereby grant this office permission to treat my 16 or 17 year old teen when they arrive at the office unaccompanied on: _____.

_____ until _____
Date of Permission End date of Permission

_____ _____/_____/_____
Signature of Parent/Legal Guardian Date

By signing this consent form it is your responsibility to discuss the office visit with your teen. Please do not call our office to review this visit. If you would like a summary of the visit please sign up for the patient portal.

COPAY AMOUNTS WILL BE DUE AT THE TIME OF VISIT. PLEASE ENSURE THAT THE PATIENT AND/OR PATIENT'S GUARDIAN IS EQUIPPED TO PAY THE COPAY AMOUNT DESIGNATED BY THE INSURANCE COMPANY.