17560 South Golden Road, Suite 100, Golden, Colorado 80401

CONSENT FOR TREATMENT OF MINORS

When appropriate, it may be more convenient to have medical care delivered to minors without having a parent present. If you wish to authorize such treatment please review, complete, and sign the following consent.

Authorization

I request and authorize *Hill Center for Dermatology, PC* and its personnel to deliver medical care to my child(ren) listed below:

Patient Name:_____ Date of Birth:_____

Patient Name:_____ Date of Birth:_____

Patient Name:_____ Date of Birth:_____

Parent's name:_____ Relationship:_____
Phone (cell): _____

Signature:_____ Date:_____

Credit Card On File Authorization

I, the undersigned, authorize and request Hill Center for Dermatology, PC to charge my credit card on file for balances due to services rendered that my insurance identifies as my financial responsibility.

This authorization relates to:

☐ Copayments only
☐ All payments not covered by my insurance company for services provided by the Hill Center for Dermatology, PC

This authorization will remain in effect until I cancel it. To cancel, I must contact Hill Center for Dermatology, PC.

Cardholder Name: _____ Signature: _____

Billing Address: _____

City _____ State _____ Zip_____

Each time credit card is charged:

☐ Email receipt to: _____
☐ Mail receipt
☐ No receipt necessary

Credit Card Number: _____ _____ _____ _____

Expiration Date: _____/_____ CVV Code: _____