

MATTHEW D. BARROWS M.D.
Dermatology & Skin Cancer Surgery Center
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MINOR CONSENT

By completing this form you are giving us the consent to see and treat your child without a parent present. Including but not limited to consent for all reasonable and necessary medical treatment and/or surgical treatment and/or other medical procedures which are required during my/our absence for the below-named and described minor child.

A minor child(ren) under the age of 18 must have a parent or legal guardian present. In the event that this is not possible we do require you complete this form and have your child bring with him/her to the appointment. If you have legal guardianship of minor child(ren) that will be coming without you we will need have a copy of your guardianship papers. If a grandparent or older sibling accompanies your child we still need a completed consent from the parents. **Co-payments, co-insurance and any outstanding balance are due at the time of service, please make sure the child will be prepared or call the office for proper arrangements.**

Patients Name: _____ Date of Birth: _____

This form is good for anytime ____ or one time only ____

If one time consent please indicate your date of appointment: _____

Parent Name (Print): _____ Phone: _____

Signature: _____ Date: _____

Emergency Medical Treatment: In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name & Relationship: _____ **Phone:** _____

Family Doctor: _____ **Phone:** _____