MAHONEY
DERMATOLOGY SPECIALISTS, P.A.

Parental Consent Form

Today's Date: _____/_____/_____

I _____ PARENT/GUARDIAN, of minor child
(Printed name of Parent/Guardian)

_____, give Mahoney Dermatology Specialists, P.A.
(Printed name of Minor Child(ren))

and staff permission to treat my minor child. This consent is limited to office visits and/or cryosurgery (freezing) or intralesional injection procedures, but does not include any other surgical procedure as it is understood that I must be present during any such surgical procedure. These include but are not limited to biopsy, shave removal, or excision performed upon my minor child. I further agree that Mahoney Dermatology Specialists, P.A. is not obligated to telephone me before or after any office visit of my minor child to discuss treatments provided or medications prescribed. My minor child is responsible for discussing diagnosis and treatments options as well as risks and benefits, with the doctor. I understand that all payments are due at time of service.

The following are authorized to bring in Child(ren) for appointments *without a parent present*:

Name	Relationship to Patient(s)

Please Note: The adult accompanying the child is responsible for copays/fees for services. Please provide payment to the accompanying adult before he/she brings in your child.

Parent or Guardian Signature: _____ Date: _____/_____/_____