Lilly Dermatology

Patient Name: _____ Date of Birth: _____

Drug Allergies: _____ Current Medications: _____

Primary Care Provider: _____ Phone: _____

I, as the legal guardian of _____, do hereby consent to any medical care determined by the physician to be necessary for the welfare of my child. I agree to assume financial responsibility for the care rendered necessary by the providing physician or staff, including, but not limited to: any co-pays and charges not covered by my insurance which are incurred as a result of this consent for treatment and care. I understand that, despite this consent, in the sole discretion of the provider, my presence during the aforementioned minor's treatment and care may be required.

Unless revoked sooner in writing, this consent remains in effect until:

☐ Minor has reached the age of 18-years-old ☐ Until the ____ of _____ 20____

Parent or Legal Guardian Name: _____

Relationship to Minor: _____ Billing Address:_____

_____

Phone Number: _____ Work Phone Number: _____

I hereby approve and empower the below listed individuals with the authority to arrange and/or consent for any and all emergent and non-emergent medical care or treatment in my absence.

Authorized Contact Name: _____ Relationship to Minor: _____

Phone Number: _____ Work Phone Number: _____

Signature of Parent or Legal Guardian: _____ Date: _____

Name of Parent or Legal Guardian: _____ Relationship to Minor: _____