CARLA J. BAUMAN, M.D.
MEDICAL & COSMETIC DERMATOLOGY

# ADVANCE CONSENT TO TREAT A MINOR

Washington State Law requires the consent of a minor's parent or guardian to medical treatment of a minor without Please complete the form below in the event a parent or guardian is unable to accompany minor child to an appointment.

I authorize Carla J Bauman MD PS and its' physicians and/or staff to provide medical care to my child, including but not limited to, diagnostic examination (including laboratory testing) treatment procedures and prescribing of medication as deemed appropriate. Should my child need more invasive diagnostic or surgical procedures, we will attempt to contact the child's parent or guardian before such care is initiated.

**My minor child will come to the office for regular treatment of his/her/they dermatological condition(s) unaccompanied by a parent or guardian.**

**Initials**
**_____ I understand that I am responsible for payment of my account at the time of service for deductible, non-covered service, medically unnecessary services, copayments and insurance balances, should my primary insurance be with a company with which the physician(s) are contracted. If my insurance company is not one with which the physician is contracted, I am responsible for the entire amount at the time of service.**

**This form shall remain in effect for 12 months from the date signed unless revoked in writing.**

_____
**Print name of parent or legal guardian**

_____ **Date:**_____
**Signature of parent or legal guardian**

_____ **DOB:**_____
**Patient**