MURFREESBORO DERMATOLOGY CLINIC, PLC

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Treatment to Minors

Many times parents find themselves unable to accompany their teen or young adult to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I hereby grant Dr. Bell, a Physician Assistant, Nurse Practitioner, and/or a Registered Nurse employed by Murfreesboro Dermatology Clinic, PLC permission to provide continued treatment to my child when he/she arrives at the office unaccompanied or accompanied by someone other than a legal guardian (grandparent, babysitter, etc.).
I understand this excludes treatment of any new symptoms.

I wish my child's treatment to be restricted as follows:

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I also understand payment of any co-payment or co-insurance is required on those dates my child is treated, whether I am present or not.

____________________________	________________________
Patient Name	Patient's Date of Birth
____________________________	________________________
Signature of Parent or Legal Guardian	Date of Signature

Form MDC-104