Print Form

# DERMATOLOGY OF CENTRAL OHIO

**DR. J. MICHAEL HOLSINGER, DO**
**VERA SMITH, PA-C**

## TREATMENT TO MINORS

Patient name: _____ Date of Birth: _____

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

I hereby grant ◯ Dr. J. Michael Holsinger ◯ Vera Smith, PA-C permission to treat my child when they arrive at the office unaccompanied by an adult.

Signature of parent/guardian: _____ Date: _____
Please select one option: ○ good for today's visit only ○ good for one year from today

### AUTHORIZATION TO CHARGE SERVICES TO CREDIT/DEBIT CARD

My minor child will be coming to the office for regular treatment of his/her dermatological condition unaccompanied. I authorize Dermatology of Central Ohio to charge my credit card under the following circumstances:

***Initials:***

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

_____ For whatever reason, should my account fall into a 45-day or later (after date of service) category, I authorize Dermatology of Central Ohio to generate charges to my credit card for that unpaid balance without further permission or notice.

_____ A receipt for charges will be mailed to my address.

☐ VISA ☐ MasterCard ☐ America Express ☐ Discover ☐ Other

Credit Card #: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Exp Date: _____ CVC: ☐☐☐☐

Name as it appears on the card: _____

Signature: _____ Date: _____