# LIFETIME AUTHORIZATION FOR TREATMENT OF MINOR

I hereby grant Dr. Sidney Possick , M.D., P.A. permission to treat my child when he/she arrives and the office unaccompanied for regular treatment of his/her dermatologic conditions.

I understand that I am responsible for payment of this account at the time of service. I agree to provide payment for any deductibles, co-payments and insurance balances prior to my child's appointment. I also agree to provide with any insurance and/ or address changes if applicable at the visit.

______________________________________________

Patient Name (print) Date of Birth

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Signature of Parent or Legal Guardian Date

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Witness Date