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Consent for Treatment of a Minor

I authorize Gerald N. Goldberg, MD and/or another designated provider or assistant, to examine, treat and/or perform all medical and/or minor surgical procedures, which may be deemed necessary, with or without the presence of a legal guardian.

I further understand that I am responsible for the costs of all medical treatments and/or procedures, whether or not such medical treatments and/or procedures are covered by insurance. I agree to pay Pima Dermatology for any and all costs incurred by the named minor patient.

Patient's Last Name ______________________ First __________________ Date of Birth _____ / _____ / _____

Guarantor's Last Name _________________________ First Name ________________

Relationship to Patient _____________________________

Signature ____ Date _______________

Revised 03/2012