



**THE CENTER**  
FOR DERMATOLOGY AND SKIN CARE INC.

**Dr. Gregory T. Lagos, FAOCD, FAAD**  
607 Chestnut Street  
South Charleston, WV 25309  
(304) 766-9136 Fax (304) 766-9139

**CONSENT TO TREAT MINOR PATIENT-WITHOUT PARENT/LEGAL GUARDIAN PRESENT**

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**Name of Child/Minor**

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**Date of Birth of Child/Minor**

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**Appointment Date**

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**Expiration Date of Consent**

**AUTHORIZATION:**

I authorize **The Center for Dermatology and Skin Care** and any provider/employee to provide medical care for this patient for whom I am the legal guardian. This consent includes contact and discussion with other health care professionals, such as my primary care physician or specialists for my care and treatment.

I also authorize **The Center for Dermatology and Skin Care** to bill my insurance company for services provided to the patient named above unless they are deemed cosmetic. I assign all payments for these services to the practice. I understand that I am responsible for all copayments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan. I further understand that my contract with my insurance may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

I have read, understand and give my consent as stipulated above.

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**Parents or Guardian's Name**

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**Phone Number**

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**Parent or Guardian's Signature**

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**Today's Date**