Minor Patient Registration Form

Minor's Name: _____ Preferred to be called: _____

Date of Birth _____/_____/_____ Sex: ☐ Male ☐ Female

Address: _____City:_____ State ____Zip:_____

Day Phone: (___) _____-_____ Evening Phone: (____) _____-_____

Legal Guardian or parent: _____ Date of Birth:_____

Day phone: (_____) _____-_____ SSN:_____

Address if Different from above:_____

Payment Policy

The adult/guardian who brings the child in will be responsible for the bill including all copayments and deductibles we do not forward bills to other parties regardless of court rulings or divorce decrees.

Insurance Subscriber Information:

Responsible party: _____ **Name of Parent:** _____

Parent's DOB: _____ **Parent's SSN**_____

Secondary Insurance

Responsible party: _____ **Name of Parent:** _____

Parent's DOB: _____ **Parent's SSN**_____

May we leave medical information about the minor on your answering machine? Yes ☐ No ☐

Do you give the office permission to discuss medical information about your minor child with family members?

Name: _____ Phone: (____) _____-_____

In case of emergency: whom shall we notify? _____

Relationship to patient: _____ Phone: (_____) _____-_____

PRIMARY CARE PROVIDER: _____

Parent/ Legal Guardian Signature

_____Date___/____/____

Scholes Dermatology, LLC
526 Shoup Ave W, Suite A
Twin Falls, ID 83301
208-734-5555

Consent for Treatment, Financial Agreement, and Records Release

Patient Name: _____ Date of Birth: _____

I, the undersigned as the patient (or authorized person), consent to any treatment and/or procedures rendered to me that may, under the judgement and instruction of the treating provider, be considered advisable or necessary. I understand that if any extensive procedure or surgery is to be procedure or surgery is to be performed, it will be fully explained to me, including the risks, benefits and alternatives, and my specific consent will be necessary. I voluntary give my consent for treatment and also my consent to any procedure that my provider performs in the dermatology clinic and deems necessary for my condition, which include but are not limited to: cryosurgery (freezing of skin lesions with liquid nitrogen), incision and drainage of abscesses and cysts, removal of skin tags, shave biopsy and punch biopsy of skin lesions and rashes, debridement of wounds, injections of skin lesions, cauterizations of skin lesions, surgery /electro cautery.

Initial _____

I understand that any ancillary services (x-rays, lab tests, pathology, slide prep etc.) that may be ordered be ordered by the medical provider while I am in the clinic are not included in my clinic bill and that I will be billed separately for those services.

In addition, I authorized **Scholes Dermatology, LLC** , along with any contracted provider or outside provider to furnish all medical and financial information related to for this visit to my insurance carrier and/or any agency working on their behalf. I hereby authorize payment of benefits on my behalf to any of the providers performing services related to this encounter. I understand that certain services may not be covered or may be denied by my insurance carrier and I hereby guarantee payment of the charges incurred and agree to pay any unpaid balances.

I, the undersigned, have read the above authorizations and understand the same and certify that no guarantees or assurances have been made as to the results or outcome of any treatment procedure or diagnosis.

_____ _____

Signature or Patient or legal Representative **Date**