



Advance Consent to Treat Minor Children (under 18 years of age)

I, _____ (name of responsible party), hereby authorize all necessary dermatological treatment, deemed necessary by the dermatologist, for:

Name of Patient: _____

Date of Birth: _____

Miller Family Dermatology may provide treatment if my child is unaccompanied to his or her appointment, or if someone other than myself accompanies my child.

I have read a copy of Miller Family Dermatology's Important Information to Parents and Guardians of Minor Children. I understand a written copy will be provided to me at any time upon my request. I understand Miller Family Dermatology has a link to the Important Information to Parents and Guardians of Minor Children on the practice website located at <https://millerfamilydermatology.com/for-patients/parent-and-guardians/>.

Signature of Responsible Party (Guarantor): _____

Name (Print): _____ **Date:** _____

Relationship to Patient: _____ **Witness Signature:** _____

Miller Family Dermatology complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Miller Family Dermatology cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-408-2431. TTY: 711.

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