Cambio Dermatology

PARENTAL CONSENT FORM

Date:___________________

I, _________________________ PARENT/GUARDIAN, of minor child
(Printed Name of Parent/Guardian)

______________________, give Cambio Dermatology, its Physicians and staff
(Printed Name of Minor Child)

permission to treat my minor child. This consent is limited to office visits or cryosurgery procedures but does not include any surgical procedure; as it is understood that I must be present during any such surgical procedure including, but not limited to, a biopsy or excision performed upon my minor child. I further agree that Cambio Dermatology will not telephone me before or after any office visit by my minor child to discuss treatments provided or medications prescribed. I understand that all payments are due at time of service and that Cambio Dermatology does not bill for co-pays or deductibles.

______________________________ ______________________________
(Parent/Guardian Signature) **Witness Signature**

______________________________ ______________________________

Printed Name of Parent/Guardian **Printed Name of Witness**