BARBA
DERMATOLOGY

TREATMENT TO MINORS:

You may send this form using the following methods:

- Fax 305.573.7092
- Email: info@barbadermatology.com
- Send with your child or caretaker

Many times parents find themselves unable to accompany their children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I (we) hereby grant Barba Dermatology permission to treat my (our) child(ren) listed below when they arrive at the office unaccompanied, or accompanied by a nanny/person who is not a legal guardian.

PLEASE PRINT

1) Name: _____

   DOB: _____

2) Name: _____

   DOB: _____

3) Name: _____

   DOB: _____

Please try to contact me (us) regarding health care of my (our) child(ren) at the following phone number(s):

Parent's Name/ Legal Gaurdian: _____

Phone (office/home/cell): _____

Signature: _____

Please Print Name and Relationship: _____

Date _____

AUTHORIZATION TO CHARGE SERVICES
TO MAJOR CREDIT CARD: FAX 305.573.7092 OR SEND WITH YOUR CHILD

This agreement is required if you wish your unaccompanied child to be seen.

My minor child will be coming to the office for regular treatment of his/her dermatological condition unaccompanied; I authorize Barba Dermatology to charge my major credit card (listed below) under the following circumstances:

Initials

_____ I understand that I am responsible for payment of my account at the time of service for deductibles, non-covered services, medically unnecessary services, co-payments, and insurance balances, should my primary insurance be with a company with which the physician(s) are contracted. If my insurance company is not one with which the physician is contracted, I am responsible for the entire amount at the time of service.

_____ Prescriptions and skincare purchased in the office

_____ Should my account have a balance determined by my insurance company, I authorize this office to generate charges to my major credit card for that unpaid balance without further permission or notice.

_____ A receipt for charges will be given to the person accompanying your child.

CREDIT CARD ACCOUNT INFORMATION: PLEASE PRESENT CARD FOR VERIFICATION

Please write in your credit card number in the boxes above

Expiration. Date: _____ Customer Code _____ Visa Master Card American Express	[ ] I prefer to keep a signed check on file made payable to Alicia Barba MD PA. The check will be processed only if I have a balance. We do not call to ask for permission. Your signature below is permission to cash the check for balances.

You are entitled to a refund should your insurance company later pay for services initially denied. We occasionally find that patients get upset at us for balances/expenses set forth by insurance companies. Please know we are on your side and will help provide you with any documents so that you fight any and all denials with your insurance company.

Signature _____ Date: _____

THIS INFORMATION IS PART OF YOUR HIGHLY CONFIDENTIAL MEDICAL RECORD AND FILED IN LOCKED CABINETS
DO NOT EMAIL THIS FORM TO US WITH YOUR CREDIT CARD NUMBER