CLEAVER DERMATOLOGY · PO BOX 7545 · 1316 COUNTRY CLUB DRIVE, KIRKSVILLE, MO 63501 · 660-627-7546

# Minor Consent

The patient has my permission as legal guardian to be seen and treated without being accompanied by myself or another adult (this visit and future visits). I understand that I will be responsible for the bill, should insurance not pay, even if I am not present at the time of the patient's visit.

_____ _____

Patient Name: Patient Date of Birth

_____ _____

Witness Signature Date Patient / Agent / Guardian Signature Date