GulfView Medical Institute PL
A new approach to health.

TREATMENT OF MINORS

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

I hereby grant GulfView Medical permission to treat my child when they arrive at the office unaccompanied.

_____ _____/_____/_____
Signature of Parent Date

AUTHORIZATION TO CHARGE SERVICES TO MAJOR CREDIT CARD

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 Gulf View Medical Institute PL to charge to my major credit card (listed below) under the following circumstances:

Please Initial Next To The Paragraphs Below

_____ I understand that I am responsible for payment of my account at the time of service for deductibles, non-covered services, medically unnecessary services, copayments 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.

_____ For whatever reason, should my account fall into a 45 day or later (after the date of service) category, I authorize this office to generate charges to my major credit card for that unpaid balance without further permission or notice.

☐ VISA ☐ MasterCard ☐ American Express ☐ Discover ☐ Other

Credit Card #: _____ Expiration Date: _____/_____/_____

Name as it appears on the credit card: _____

Signature: _____ Date: _____/_____/_____