NORTHEAST TARRANT DERMATOLOGY, INC.

Tho Q. Nguyen, M.D.
Douglas R. Farris, M.D.
Stacy R. Beaty, M.D.
Alice Wuu, M.D.

Treatment of a Minor

Please print all information until signature.

Name of Minor Patient:_____

Minor Patient's Date of Birth: _____

Parent/Guardian Name:_____

Parent/Guardian Contact Number:_____

Any Known Allergies: _____

_____

Since I will not be present in the office, I am giving written consent for the above listed minor to receive medical treatment at Northeast Tarrant Dermatology (NETD) from this date forward. This treatment may include in-office procedures and prescriptions. I also agree to assume financial responsibility for all expenses of such care and understand that payment for any services rendered is to be made on the day that treatment is provided. At any time, this authorization may be revoked in writing and given to NETD.

Signature of Parent or Guardian: _____

Date consent begins:_____