LIMMER DERMATOLOGY
Your Skin. Our Specialty.

14615 San Pedro Ave. Ste. 210
San Antonio, TX 78232
Ph: 210-496-9929 Fax: 210-496-6699

Parental Consent Form

I _____ give permission for the Doctors Limmer (or staff) to treat my (son, daughter)
(Parent Name) (circle one)

_____ who is a minor. I will make sure that the visit is paid for at the time of service
(Patient Name)

by cash, check, or credit card. I will be responsible for my child's bills until further notice. I understand that it is my child's responsibility and not the doctors to tell me what transpired at the visit. The Doctors will notify me if there is a major decision to be made.

☐ My minor child will be alone at the appointment.

☐ My minor child will be accompanied with _____.
(Name) (Relationship)

_____

(Parent Print Name) (Parent Signature) (Date)

_____

(Limmer Dermatology Rep Print Name) (Limmer Dermatology Rep Signature) (Date)

Approved 01/21/2016