Elevated Dermatology and Skin Cancer Surgery Center

10345 Parkglenn Way, Suite 100 Parker, CO 80138

P: 720-851-5200 F: 720-851-5200

Email: patient@elevatedderm.com

Consent to be seen without a parent/guardian present

My child _____(DOB:___/___/20__)can be seen without a parent present for future appointments.

Parent/Guardian Name:_____Signature:_____Date:_____

Consent to receive treatment without a parent/guardian present

I _____ give consent to Dr. Christopher Messana, Dr. Kate Messana, Dr. Zachary Jones, or one of Elevated Dermatology and Skin Cancer Surgery Center's designated employees to perform the following procedure(s) on my child:

Minor Child:_____ DOB:_____/_____/20___

Parent/Guardian Name:_____Signature:_____Date:_____

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Minor Child:_____ DOB:_____/_____/20___

Parent/Guardian and Guarantor Signature:_____ Date:_____