

Arkansas Physical Medicine
636 W. Broadway
North Little Rock, AR 72114
501-374-1153

Minor Patient Consent Form for Cosmetic Laser Treatment

Patient Name: _____ **Date of Birth:** _____
First Middle Last Month Day Year

Legal Guardian or Parent Name: _____ **Date of Birth:** _____
First Middle Last Month Day Year

Home Address: _____
Street # Street Name City State Zip

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Emergency Contact #:** _____
Name of emergency contact person _____

I _____ acknowledge and accept all of the following:
Parent or legal guardian

There is risk associated with Cosmetic Laser Treatment and I have had the opportunity to ask questions and have had my questions answered.

I am the adult presenting the child for treatment; I am responsible for payment of services rendered at the time of treatment.

I am aware of the 24 hour notice of cancellation. I am also aware of the \$50.00 service fee. I as the adult am responsible for calling to cancel appointments within 24 hours of appointment time.

The fees for services have been discussed with me.

Signature: _____
Parent or legal guardian

Cosmetic Laser Specialist: _____

Do we have permission to?

Leave a message on your answering machine at home? ___ yes ___ no

Leave a message at your place of employment? ___yes ___no

Discuss treatment with any member of your household other than yourself? ___ yes ___ no

If yes, whom: _____ **Relationship to minor** _____