POLICY FOR TREATMENT OF MINORS

A parent or legal guardian accompanying the minor is responsible for the payment of the patient's account regardless of who holds the insurance policy. Unaccompanied minors can be denied non-emergency treatment until a parent or legal guardian is present or until such time as we receive written permission for the treatment and payment of the account.

We require that all minors be accompanied by a parent or legal guardian for the **initial** visit, we will see minors without a parent or guardian if the parent or guardian has provided written permission.

AUTHORIZATION TO PROVIDE DENTAL CARE FOR MINOR

I am the custodial parent having legal custody of ___________________, a minor (under age 18) child, date of birth _________. I authorize my child to consent to care and/or treatment at ***Aaron Tropmann, DDS.PA. & Gary D. Oyster, DDS.*** without my presence. By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full importance of this grant. I understand and agree that I am liable for any and all charges incurred by the treatment of the above patient.

Limitations on such consent and treatment are as follows (if none write none on the line below).

This consent has the following time limitation (if none write none on the line below).

Custodial Parent Contact Information (please print):

________________________________	______________________________
Custodial Parent Name	Work Phone Number
________________________________	________________________________
Home Phone Number	Mobile Phone Number
________________________________	________________________________
Custodial Parent Signature	Date