



Consent to Treat Patients with a Legal Guardian/POA

At Allied Dermatology and Skin Surgery, LLC all patients with an intellectual disability or neurological condition, someone who cannot make intellectual decisions regarding their own medical treatment must have a signed consent by a legal guardian/POA for each office visit in order to be seen. **A copy of the notarized documentation of a court appointed guardian/POA needs to be on file for the patient.** The patient must have a responsible representative present for any scheduled appointment if the legal guardian/POA is not available.

I hereby give permission for the providers and staff at Allied Dermatology and Skin Surgery, LLC to provide treatment to _____ for their dermatological condition(s).
(Patient Name)

Date of Scheduled Visit: _____

Patient's Name: _____

Patient's DOB: _____

List reason(s) for examination/ treatment/biopsy or surgical procedure: _____

(i.e. acne, eczema, concerning lesion)

I, _____ am the legal guardian/POA of the above listed patient. I have the legal right to consent for medical treatment for this patient. I hereby authorize Allied Dermatology and Skin Surgery, LLC to provide medical treatment for the above indicated condition(s). I understand that this consent will be valid for the above date of service only.

Legal Guardian/POA Name

Legal Guardian/POA Signature

Date

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