

NOTICE TO PARENTS

Patient ID# _____

Parents often find it difficult to accompany their minor children to routine follow up appointments. This form has been created to give you the opportunity to authorize both treatment and payment for your minor child in your absence.

AUTHORIZATION FOR TREATMENT OF A MINOR

I authorize **Dr. Kay A Johnston** to render treatment to my minor child

(Child's Name) _____, without my

presence in the office.

Signature

Date

AUTHORIZATION FOR PAYMENT BY CREDIT CARD

I authorize the office of **Dr. Kay A. Johnston** to make charges to the credit card account listed below in payment for treatment rendered to my minor child (Child's Name) _____.

Visa Mastercard American Express Discover

Credit Card Number

Expiration Date

Authorization Number (in signature strip on back of the card)

Signature of cardholder