



## Temporary Guardian Form

**\*\* Only valid for follow up visits.\*\***

**\*\*New Patient visits require Parent presence at appointment\*\***

Service(s): \_\_\_\_\_  
\_\_\_\_\_

Date of service(s): \_\_\_\_\_

I, \_\_\_\_\_, (parent/guardian)

of \_\_\_\_\_ (minor patient)

with date of birth \_\_\_\_\_ am consenting to allow a temporary

guardian (over 21 years old) to bring him/her to the visit or service (s) in the absence of me personally being in the office.

Temporary Guardian: \_\_\_\_\_ (Verified with ID)

Relationship: \_\_\_\_\_

I understand that NO ADDITIONAL services will be performed today unless an updated consent has been completed. I also understand that I am required to complete an updated Temporary Guardian Form for each subsequent appointment date. I understand that the Temporary Guardian must show identification at the time of the visit.

I also consent for the Temporary Guardian to have access to the minor's Protected Health Information for this visit.

I also understand that payment is required in full for copay or service delivered at the time of service.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Updated 4/16/24

S:chartprep

P- 610-828-0400

F- 610-828-3869

[www.plymouthmeetingdermatology.com](http://www.plymouthmeetingdermatology.com)