



**ALPINE
DERMATOLOGY**

Dr. Cheryl Lee D. Eberting, M.D.
Board Certified Dermatologist
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Consent to treat a minor:

I hereby grant Alpine Dermatology permission to treat my child when they arrive at the office unaccompanied.

I understand that I am responsible for payment of my account at the time of service for all services rendered.

Minor's name: _____

Signature of Parent: _____

Date: _____