



1906 S. Vista Ave, Boise, ID 83705
208.433.1114 Phone
208.433.1115 Fax

975 NW 16th St, Fruitland, ID 83619
208.452.7450 Phone
208.452.7550 Fax

idahoskinsurgerycenter.com

Jared Scott, MD
Jessie Zimmerman, PA-C
Katelyn Wade, PA-C
Logan Hawker, PA-C
Brittney Irons, FNP-C

Consent for Treatment: Unemancipated Minor

Minor Patient: _____

DOB: ___/___/___

- Authority.** I am the parent, guardian or other person legally authorized by Idaho law to consent for health care services for the Minor patient pursuant to Idaho Code 32-1015.
- Consent for treatment.** I voluntarily consent to and authorize provider group and its employed or affiliated physicians, and/or practitioners to render care services to the minor patient based on the option I select below:
 - Decline consent. Minor patient must be accompanied with a parent or legal guardian during each visit. I understand that if a parent or legal guardian is not present, the minor patient will not be seen and services will not be provided.
 - Full consent. Medical evaluation, diagnosis and treatment; diagnostic services including lab tests or radiology procedures; prescription and administration of medications; counseling; and any other health care services as defined in I.C. 32-1015 deemed reasonably necessary and appropriate by the treating Provider. This consent shall constitute a "blanket consent" within the meaning of I.C. 32-1015(4)(a) and no further consent is required to authorize such health care.
 - Consent for Limited Care (i.e. office visit but no procedures, authorized person to attend, etc.). Describe: _____
- Information.** The provider has explained the nature of the proposed health care services, alternatives, and their related risks and benefits, or I have waived my right to receive such information. I have had the opportunity to ask questions and they have been answered to my satisfaction or I have declined to ask such questions. If I have questions concerning additional information, I will contact the practice or the Provider to discuss. I understand the practice of medicine is not an exact science and no promises or guarantees have been made nor can they be made to me concerning the outcome of the health care services. NOTE: Not used as permission for vaccines.
- Financial Responsibility:** I agree that I am ultimately responsible for payment for the health care services rendered to the minor patient and agree to comply with groups financial policies. I will promptly pay any co-payments, deductibles or other amounts not covered by applicable insurance or third-party payor program. I hereby assign to group the right to submit claims for payment to third-party payors and retain such payments. To the extent allowed by law, I will remain responsible for any amount not paid by any third-party payor for health care services, including but not limited to costs relating to infectious, contagious, or communicable diseases within the meaning of I.C. 39-3801. If the minor patient's account becomes delinquent, I agree to pay according to the groups financial policies, including but not limited to reasonable cost of collection, collections agency fees, attorney's fees, and court costs.

I have read, understand, and agree to the foregoing, and I understand and acknowledge that provider group and/or its providers will render health care services in reliance on this consent. This consent shall remain in effect until revoked in writing, by parent(s) or legal guardian(s), or until child may legally consent for him or herself.

Printed Name

Date

Signature

Relationship to Minor