Hayden Lake
FAMILY PHYSICIANS

8181 Cornerstone Dr. • Hayden Lake, ID 83835 • Telephone (208) 772-0785

CONSENT FOR TREATMENT:
UNEMANCIPATED MINOR

Minor Patient: _____ Birthdate: ____/_____/_____

1. **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.

2. **Consent for Treatment.** I voluntarily consent to and authorize Hayden Lake Family Physicians and its employed or affiliated physicians, practitioners, and staff (collectively "Providers") to render the following health care services to the Minor Patient:

[ ] **General 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. I understand that my General Consent specifically authorizes my child to obtain health care services including but not limited to, reproductive health services, immunizations, mental health care, and substance abuse services. This consent shall constitute a "blanket consent" within the meaning of I.C. § 32-1015(4)(a) and is specifically intended to authorize such health care services.

OPT OUT: By checking a box below, I am specifically excluding the identified health care services indicating I DO NOT provide General Consent for the identified health care service unless otherwise later agreed:

[ ] **Reproductive Health Services**, including but not limited to, obstetric and gynecological care (including prenatal, child delivery, and postpartum care), contraception, sexually transmitted infection

[ ] **Immunizations**, including but not limited to, influenza, COVID-19, MMR (measles, mumps, rubella), TDAP (tetanus, diphtheria, acellular pertussis), Hepatitis

[ ] **Mental Health Care**, including but not limited to, counseling, mental illness or psychiatric diagnosis/treatment

[ ] **Substance Abuse Services**, including but not limited to, behavioral therapy, detox treatment, counseling, education.

3. **Information.** The Provider has explained the nature of the proposed heath 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 all my questions have been answered to my satisfaction or I have declined to ask such questions. If I require additional information concerning the health care services, I will contact Hayden Lake Family Physicians or the Provider to discuss such services. I understand that 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.

4. **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 Hayden Lake Family Physicians Financial Policies. I will promptly pay any co-payments, deductibles, or other amounts not covered by applicable insurance or third-party payor program. I will cooperate with Hayden Lake Family Physicians in obtaining reimbursement for the health care services from any third-party payor, and hereby assign to Hayden Lake Family Physicians the right to submit claims for payment to third-party payers and retain

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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 interest and fees according to Hayden Lake Family Physicians Financial Policies, including but not limited to reasonable costs of collection, collection agency fees, attorneys' fees, and court costs.

I acknowledge that I will be presented with this Agreement once every year, and it will apply to all encounters for the identified minor child with Hayden Lake Family Physicians that happen during the year.

I have read, understand, and agree to the foregoing, and I understand and acknowledge that Hayden Lake Family Physicians and/or its Providers will render health care services in reliance on this consent.

_____ Date: _____/_____/_____
Name

_____
Phone Number

_____
Relationship to Minor Patient

I appoint, _____, as a medical proxy decision maker for consenting to medical care for minor _____. I have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority so delegated. Be advised that protected patient health information may be shared with the proxy to facilitate informed consent making.

Identify any limitations on the kinds of medical services for which this consent by proxy is given. If none, state "none". _____
_____

I am aware that I am responsible for all charges incurred at Hayden Lake Family Physicians by my minor child.

_____ Date: _____/_____/_____
Name

_____
Phone Number

_____
Relationship to Minor Patient

I consent for the minor _____ to present alone for treatment with this signed consent. I am aware that I am responsible for all charges incurred at Hayden Lake Family Physicians by my minor child.
_____ Date: _____/_____/_____
Name

_____
Phone Number

_____
Relationship to Minor Patient