Consent to Treatment

CONSENT FOR TREATMENT: UNEMANCIPATED MINOR

Minor Patient: _____ Birthdate: _____/_____/_____
Print patient name

Minor Patient: _____ Birthdate: _____/_____/_____
Print patient name

Minor Patient: _____ Birthdate: _____/_____/_____
Print patient name

Minor Patient: _____ Birthdate: _____/_____/_____
Print patient name

Minor Patient: _____ Birthdate: _____/_____/_____
Print patient name

Authority

I am the parent, legal 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 Frontier Pediatric Providers (FPP) 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; administration of vaccinations; contraception and counseling, including but not limited to care relating to communicable diseases and counseling; 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 services.

[ ] Delegation of Authority

I authorize: to consent to health services for the Minor Patient and authorize FPP and its Providers to rely on such consent as if from me

_____
Print name(s) of person authorized

_____
Print name(s) of person authorized

[ ] Consent for Specific Care [describe]

I give consent for minor child to attend their medical appointment at FPP unaccompanied by parent.

_____

_____

_____

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 FPP or my child(s) Primary Care 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.

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 FPP 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 FPP in obtaining reimbursement for the health care services from any third-party payor, and hereby assign to FPP the right to submit claims for payment to third-party payers 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 interest and fees according to FPP Financial Policies, including but not limited to reasonable costs of collection, collection agency fees, attorneys' fees, and court costs.

I have read, understand, and agree with the foregoing, and I understand and acknowledge that FPP and/or its Providers will render health care services in reliance on this consent.

_____ Date: _____/_____/_____

Print Name of Parent or Guardian

_____

Signature

_____

Phone Number

_____

Relationship to Minor Patient