Consent for Treatment: Unemancipated Minor

____ _____/_____/_____

Last Name First Name Middle Name

1. 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. I voluntarily consent to and authorize Kootenai Health and its employed or affiliated
defined in I.C. § 32-1015 deemed reasonably necessary and appropriate by the treating Provider. I un
General Consent specifically authorizes my child to obtain health care services including but not limit
reproductive health services, immunizations, mental health care, and substance abuse services. This co
constitute a "blanket consent" within the meaning of I.C. § 32-1015(4)(a) and is specifically intended
health care services.

Mental Health Care, including but not li

[ ] ***Substance Abuse Services***, includin
education

3. The Priis2.6(i)-4 5.957s vx.957

Patient Identification – Write in or attach patient label

Name:

MRN #:

CSN #:

Age/Sex:

- Consent Minor

and hereby assign to Kootenai Health 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 payer 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 Patient's account becomes delinquent, I agree to pay interest and fees according to Kootenai Health's 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 within Kootenai that happen during that year.

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

____ Date: ____/_____/_____ Time_____________
Parent / Guardian Name

____
Parent / Guardian Signature

____
Phone Number

____
Relationship to Minor Patient

Patient Identification – Write in or attach patient label

Name:

MRN #:

CSN #:

Age/Sex:

- Consent Minor