



## CONSENT FOR TREATMENT: UNEMANCIPATED MINOR

Minor Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Authority

I am the parent, legal guardian, or other person legally authorized by Idaho law to consent for health care services for the above-named minor patient pursuant to **Idaho Code 32-1015**.

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

### Consent for Treatment

I voluntarily consent to and authorize the provider group, its employed or affiliated physicians, and/or practitioners to render care services to the minor patient based on the option I select below:

- ☐ **Consent for Limited Care: For patients ages 15 and older ONLY**  
Includes: office visits only, no procedures, no surgical planning or scheduling without an authorized person accompanying the minor patient.
- ☐ **Decline Consent:** The minor patient must be accompanied by a parent or legal guardian at **every visit**. I understand that if a parent or legal guardian is not present, the minor will not be seen, and services will not be provided.
- ☐ **Full Consent: For patients ages 16 and older ONLY**  
Includes: medical evaluation, diagnosis and treatment; diagnostic services (e.g., lab tests or radiology); prescription and administration of medications; or other health care services as defined in **I.C. 32-1015** deemed reasonably necessary by the treating provider.

### Financial Responsibility

- I agree as the designated parent/guardian, that I am ultimately responsible for payment for services rendered to the minor patient and will comply with the group's financial policies.
- I will promptly pay any copayments, deductibles, or uncovered amounts.
- I assign to the group the right to submit insurance claims and retain payments.
- To the extent permitted by law, I remain responsible for balances unpaid by third-party payors, including costs relating to infectious or communicable diseases (as defined in I.C. 39-3801).
- If the account becomes delinquent, I agree to pay all applicable costs including collection fees, attorney's fees, and court costs.

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### Acknowledgment & Signature

I have read, understood, and agree to the terms above. I understand and acknowledge that the provider group and its practitioners will rely on this consent to render care.

**This consent will remain in effect until revoked in writing by a parent or legal guardian, or until the minor reaches the legal age of consent.**

Parent/Guardian Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_