NORTH IDAHO EYE INSTITUTE

Phone: 208-667-2531
Fax:208-765-9385

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 North Idaho eye Institute (GROUP) 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; dilation of pupils, 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 services.

   or

   [ ] Consent for Specific Care [Describe]: _____
   _____
   _____

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 GROUP 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 GROUP's 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 GROUP in obtaining reimbursement for the health care services from any third-party payor, and hereby assign to GROUP 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 GROUP's 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 to the foregoing, and I understand and acknowledge that GROUP and/or its Providers will render health care services in reliance on this consent.

_____ Date: _____/_____/_____
Legal Guardian/Parent Printed Name

_____
Phone Number

Signature of parent or legal guardian: _____