Lifestages OBGYN and Family Medicine

Name of Minor Patient: _____ Date of Birth: _____

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 Lifestages OBGYN and Family Medicine 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. 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 health care services, alternatives, and their related risks and benefits, or I have waived my right to receive such information. I have declined to ask such questions. If I require additional information concerning the health care services, I will contact Lifestages OBGYN and Family Medicine 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 Lifestages OBGYN and Family Medicine Financial Policies. I will promptly pay any co-payments, deductibles or other amounts not covered by applicable insurance or their-party payor program. I will cooperate with Lifestages OBGYN and Family Medicine in obtaining reimbursement for the health care services from any third-party payor, and herby assign to Life Stages OBGYN and Family Medicine 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 Lifestages OBGYN and Family Medicine financial Polices, including but not limited to reasonable cost of collection, collection agency fees, attorney fees and court costs.

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

_____ _____ _____

Signature of parent or Guardian | Printed Name | Date

Relationship to minor: _____

Contact information for parent/guardian: _____

Phone Number