Clearwater Valley Health
301 Cedar
Orofino, ID 83544
208.476.4555 tel
smh-cvhc.org

St. Mary's Health
701 Lewiston Street
Cottonwood, ID 83522
208.962.3251 tel
smh-cvhc.org

Consent for Treatment: Unemancipated Minor

Minor Patient: _____ **Birthdate:** _____/_____/_____
Last Name First Name Middle Name

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 St. Mary's Health/Clearwater Valley Health (SMH-CVH) 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. I understand that my General Consent specifically authorizes my child to obtain health care services including but not limited to, reproductive health services, immunizations, mental health care, and substance abuse services. This consent shall constitute a "blanket consent" within the meaning of I.C. § 32-1015(4)(a) and is specifically intended to authorize such health care services.

OPT OUT: By checking a box below, I am specifically excluding the identified health care services indicating I DO NOT provide General Consent for the identified health care service unless otherwise later agreed:

[ ] ***Reproductive Health Services***, including but not limited to, obstetric and gynecological care (including preatal, child delivery, and postpartum care), contraception, sexually transmitted infection

[ ] ***Immunizations***, including but not limited to, influenza, COVID-19, MMR (measles, mumps, rubella), TDAP (tetanus, diphtheria, acellular pertussis), Hepatitis

[ ] ***Mental Health Care***, including but not limited to, counseling, mental illness or psychiatric diagnosis/treatment

[ ] ***Substance Abuse Services***, including but not limited to, behavioral therapy, detox treatment, counseling, education

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 SMH-CVH 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 SMH-CVH's Financial Policies. I will promptly pay any copayments, deductibles, or other amounts not covered by applicable insurance or third-party payor program. I will cooperate with SMH-CVH in obtaining reimbursement for the health care services from any third-party payor, and hereby assign to SMH-CVH 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 SMH-CVH'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 SMH-CVH that happen during that year.

I have read, understand, and agree to the foregoing, and I understand and acknowledge that SMH-CVH 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

Consent for Treatment: Unemancipated Minor

Patient Identification – Write in or attach patient label if available

Name:
MRN #:
CSN #:
Age/Sex: