BLANKET CONSENT FORM FOR HEALTH CARE SERVICES FOR MINOR

Providing blanket consent is optional and may, instead, be given on a case-by-case basis. Blanket consent may be withdrawn by a parent at anytime.

Minor Patient's Name: _____ **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 provide blanket consent to and authorize Primary Health Medical Group ("PHMG") and its employed or affiliated physicians, practitioners, and staff (collectively "Providers") to render health care services to the Minor Patient as deemed reasonably necessary or appropriate by the treating Provider, including but not limited to 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.

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 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 PHMG's Financial Policies. I will promptly pay any co-payments, deductibles, or other amounts not covered by applicable insurance or third-party payor for all health care services rendered to the Minor Patient. I will cooperate with PHMG in obtaining reimbursement for the health care services from any third-party payor and assign to PHMG 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. If the Minor Patient's account becomes delinquent, I agree to pay interest and fees according to PHMG's Financial Policies.

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

_____ Date: _____/_____/_____
Parent or Legal Guardian Signature

_____ _____
Parent or Legal Guardian Printed Name — Relationship to Minor Patient

_____ _____
Phone Number — Patient Account Number (filled out by office)