MERIDIAN ADVANCED PSYCHIATRY

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 Meridian Advanced Psychiatry (MAP) and its employed or affiliated practitioners and staff (collectively "Providers") to render the following health care services to the Minor Patient:

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

   or

   [ ] 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 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.

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 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 healthcare services, I will contact MAP or the provider to discuss them. 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 MAP'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 MAP in obtaining reimbursement for the health care services from any third-party payor and hereby assign to MAP 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 MAP's Financial Policies, including but not limited to reasonable collection costs, collection agency fees, attorneys' fees, and court costs.

MERIDIAN ADVANCED PSYCHIATRY

I have read, understood, and agreed to the foregoing. I also understand and acknowledge that MAP and/or its providers will render healthcare services based on this consent.

_____ Date: _____/_____/_____
Name

_____
Phone Number

_____
Relationship to Minor Patient