Nimiipuu Health

CONSENT FOR TREATMENT: UNEMANCIPATED MINOR

NOTE TO PROVIDER WHO IS CONSIDERING USING THIS FORM:
Nimiipuu Health is a tribal health clinic operated with funding from the Nez Perce Tribe, the Indian Health Service, and revenue from third party insurers. As a sovereign government, the State of Idaho does not have jurisdiction over the Nez Perce Tribe, or the services provided by the Tribe. By utilizing this form (which cites to Idaho law) we are not acknowledging or otherwise conceding that Idaho law would apply to this clinic. However, it is useful to look to these new Idaho restrictions as guidance that you, as providers, may look to, as you work toward providing consistent quality care to all patients.

Looking to Idaho law, as guidance, regarding Parents' Rights in Medical Decision-Making Act, I.C. § 32-1015, this form would provide "blanket consent" for up to one year upon signature by a parent.

Relying on a general or blanket consent without providing information sufficient to make the consent informed carries some risk. Providers should weigh the risk when deciding whether to rely on a blanket or general consent or to obtain specific consent that is sufficiently informed.

Minor Patient: _____ **Birthdate:** ____/____/____

1. **Authority**. I am the parent, guardian or other person legally authorized by law to provide consent for health care services for the Minor Patient, pursuant to the definition of parent or guardian in Nez Perce Tribal Code.

2. **Consent for Treatment.** I voluntarily consent to, and authorize, Nimiipuu Health and its employed or affiliated physicians, practitioners, and staff to provide 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; reproductive and mental health services, and any other health care services, as defined in I.C. § 32-1015 deemed reasonably necessary and appropriate by the treating Provider.

   or

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

   _____

   _____

3. **Financial Responsibility.** Other than direct care at Nimiipuu Health, or my family insurance, I agree that I may be ultimately responsible for payment for the health care services rendered to the Minor Patient and agree to comply with Nimiipuu Health Financial Policies.

4. Before this form is signed by the parent or legal guardian, the Minor Patient must be at least fourteen (14) years of age.

5. This consent may be revoked at any time by the parent or legal guardian or if there is a change of circumstances. Revoking consent must be in writing and proof of circumstances provided.

6. ☐ **I do not Consent for my minor to have this blanket consent.**

I have read, understand, and agree to the foregoing, and I understand and acknowledge that Nimiipuu Health and/or its Providers will render health care services in reliance on this Consent. This consent is valid for one year after it is signed, or until the consent is revoked by parent or legal guardian, or upon the child becoming an adult.

_____ _____

Parent's Name Parent's Signature Date

_____

Relationship to Child