orchidhealth
Exceptional, local healthcare

CONSENT FORM - MINOR

Oregon state law requires a parent or legal guardian's consent to provide medical treatment to an individual under 15 years of age, with the exception of 14-year-olds and up for outpatient mental health services and Reproductive Health Services of Any Age in Oregon. **ORS 109.640, ORS 109.675.

I understand the following types of services are offered through Orchid Health:

- Routine physical exams, including sports physicals
- Early detection, diagnosis, and treatment of illness and injury treatment of minor injuries
- Management of Chronic Health Conditions
- Age-appropriate reproductive health
- Routine lab tests, Immunizations
- Prescription medications
- Mental health services
- Referral for health care services not provided by Orchid Health

Authorization of Payment: I assign and authorize direct payment to Orchid Health of all insurance and plan benefits that are payable for services received and as otherwise permitted or required in the Notice of Privacy Practices. I fully understand that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

** SBHC's (School Based Health Clinic's), students receive care at no cost for Orchid Health Services.

Notice of Privacy Practices: I acknowledge receipt of Orchid Health's Notice of Privacy Practices. This notice can be found on our website under patient forms, is available at the clinic upon check-in, and is otherwise available to me at any time upon request.

Patient Rights and Responsibilities: I acknowledge receipt of Orchid Health's Patient Rights and Responsibilities. These can be found on our website under patient forms, are available at the clinic upon check-in, and are otherwise available to me at any time upon request. I acknowledge receipt of information regarding Patient Rights and may accept or refuse care at any time. I understand I have the right to ask questions about and refuse these services. I acknowledge that I have the right to refuse care or withdraw my consent for care, without affecting my right to future care or treatment.

Consent to Access Historical Prescription/Pharmacy Records, and to Reach out to local Hospital Networks to Access Health History Information: I authorize the release of my or my child's historical health information, as accurate information is necessary for the provision of accurate and quality medical care.

Consent to Call: I consent to receiving calls (or my parent/guardian, when applicable) from Orchid Health for my or my child's protected healthcare and other services at the phone number(s) provided to the practice, including my wireless number. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

I have read and fully understand the above information and have asked questions about anything not clear to me. I understand that I may revoke this consent at any time.

Patient Name:_____ Patient DOB:_____ Today's Date:_____

Minor Signature:_____(Age 15+/medical and age 14+ for outpatient mental health treatment)

I (parent/legal guardian): _____

give permission for my child, _____, to receive medical/mental health care at Orchid Health.

Parent/Guardian Name: _____ Today's Date: _____

Parent/Guardian Signature: _____ Relationship to Patient: _____