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 for sexual health and mental health services. * *ORS 109.610, 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

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.

I (parent/legal guardian) _____give permission for my child, _____, to receive medical/mental health care at Orchid Health.

Authorization of Payment:

Parent or Guardian: I assign and authorize direct payment to Orchid Health of all insurance and plan benefits that are payable for service(s) I receive and authorize the release of any medical records necessary to facilitate my child's treatment to process claims 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 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 from Orchid Health for 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.

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

Parent/Legal Guardian Signature _____ Relationship to Patient _____