orchidhealth
Exceptional, local healthcare

Confidential Appointment & Minor Self Consent Form

Oregon state law allows minors age 15 and older to self-consent for medical and 14 and older for mental health care. In addition, minors of any age can self-consent for family planning, sexually transmitted disease services, and certain mental health services. ORS 109.610, ORS 109.640, ORS 109.675.

I,_____ am choosing to SELF-CONSENT for medical and/or mental health treatment at Orchid Health.

_____ I am requesting **CONFIDENTIAL ONLY** medical/mental health services today, that will not be reported to my parents or guardian. I understand that Oregon Law allows for minors to request confidential medical services, for treatment related to Birth Control, Pregnancy, Sexually Transmitted Infections, and some Mental Health Services. I am currently _____ years old.

** Please **INITIAL** all lines below indicating that you understand.

_____ **Tests:** I understand that some tests are not able to be performed at Orchid, and it might be necessary to contact my parents in order to have these necessary tests performed at a different location. Or it might be necessary to contact my parents if a referral to an outside source needs to be processed. I will be informed if my parents need to be involved in this circumstance.

_____ **Parents:** I understand that there are some laws that will require parental involvement, despite my request for Confidential Services, and that Orchid Health will work very hard to ensure my Confidentiality while also abiding by these laws. I will be informed if my parents are required to legally be involved in my health condition.

_____ **Payment:** I understand that if I am a student of _____District, I will not be personally responsible for any medical bills as a result of today's Office Visit. I also understand that if my visit today is NOT confidential, Orchid will be requesting insurance information from myself or my parents/guardians to assist with payment for any services received today.

_____ **Notice of Privacy Practices:** I acknowledge receipt of Orchid Health's Notice of Privacy Practices. This notice is provided the first time I receive services from Orchid Health 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, and are available at the clinic upon check-in.

Patient Name: _____ Date of Birth: _____

Signature: _____ Today's Date: _____