Orchid Pediatrics, Inc.
4850 SW Scholls Ferry Rd, Suite 301
Portland, OR - 97225-1669

Orchid Pediatrics – Consent for Treatment

Patient Name: * _____

Date of Birth: * _____

At Orchid Pediatrics, we want to ensure that all patients (and guardians) understand their rights, treatment options, and responsibilities. Please review the following carefully:

1. Consent for In-Person Care

- I have the right to be informed about my health condition(s) and recommended treatment.
- My provider will discuss potential benefits, risks, and alternatives to treatment.
- I authorize the providers and qualified staff of Orchid Pediatrics to administer medical services, diagnostic procedures, medications, and other care deemed necessary for my treatment.
- I understand that no promises or guarantees have been made regarding treatment outcomes.
- I acknowledge that qualified staff may participate in my care under provider supervision.

2. Consent for Telehealth Services

Telehealth includes visits conducted by secure video, audio, or telephone.
- I understand that telehealth differs from in-person visits in that there is no direct physical contact.
- My provider will determine whether my condition is appropriate for telehealth care.
- I understand that technical failures (e.g., poor transmission quality) may affect service delivery.
- I agree to hold Orchid Pediatrics and its providers harmless for information lost due to technical issues.
- I acknowledge that some personal health information may be shared with third parties (e.g., insurance, when applicable) in the same way as for in-person visits.
- Orchid Pediatrics does not contract with insurance companies. I am responsible for the full cost of telehealth services and for determining whether my insurance offers any out-of-network reimbursement.
- This consent applies to all future telehealth (audio, video, or phone) visits and consultations at Orchid Pediatrics.

3. Patient Responsibilities

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- I understand that Orchid Pediatrics does not provide 24/7 coverage. If urgent needs arise, I will contact my primary care provider, go to the emergency department, or call 911.

- Orchid Pediatrics is a specialty clinic and does not provide primary care. I agree to maintain a primary care provider.
- If I am prescribed psychotropic medications by another provider, I must fully disclose this information to Orchid Pediatrics and provide a signed release of information.

HIPPA & Privacy Acknowledgment

- I understand my rights regarding the privacy of my health information under HIPAA.
- I acknowledge that I have received or had access to Orchid Pediatrics' Notice of Privacy Practices, which describes how my health information may be used and disclosed.

Acknowledgement of Understanding

By signing below, I acknowledge that:
- I have read and understood this consent form.
- I agree to the policies above and provide consent for in-person and telehealth treatment at Orchid Pediatrics.
- I give my oral and written consent to the evaluation and treatment for my current condition, as well as for any future conditions for which I seek care at Orchid Pediatrics.

PATIENT / GUARDIAN SIGNATURE * _____

Date * _____

Printed Name * _____

Relationship (if applicable) * _____