CENTRAL OREGON PEDIATRIC ASSOCIATES (COPA)
2500 NE PROFESSIONAL CT, BEND, OR 97701

PHONE: (541) 389-6313 – WWW.COPAKIDS.COM

CONSENT TO TREAT

Patient Information

Child's Full Name:
MRN:
Date of Birth:

1. Purpose of This Consent

This consent allows Central Oregon Pediatric Associates (COPA), including its physicians, nurse practitioners, physician assistants, nurses, behavioral health clinicians, medical assistants, trainees, and other supervised clinical personnel, to provide healthcare services to the above-named child at any COPA location or approved telehealth setting.

2. Consent to Routine Medical Care

I voluntarily consent for my child to receive medical care and treatment that is considered necessary and appropriate by the healthcare providers of this practice. This may include history taking, physical examinations, diagnostic procedures, laboratory testing, immunizations, medications, and other routine healthcare services normally used in the evaluation and treatment of medical conditions.

I understand that routine diagnostic and therapeutic procedures associated with preventive and acute pediatric care may be performed, including immunizations as recommended by clinical guidelines, unless I decline a specific service.

I understand that healthcare is not an exact science, and no guarantees have been made to me regarding the results of any evaluation or treatment

I understand that certain procedures, such as sedation, surgical procedures, allergy immunotherapy initiation, or procedures with significant risk, require separate written or verbal consent.

3. Oregon Minor Consent and Confidentiality (ORS 109.610–109.675)

I understand that under Oregon law:

- Minors 15 years and older may consent to their own medical, dental, and mental health treatment.
- Minors of any age may consent to STI/HIV services, birth control, pregnancy-related care, and substance use treatment.
- When minors authorize their own care, COPA may not share visit details, results, or clinical information with parents/guardians without the minor's written permission, unless allowed by law.
- Insurance may still be billed for these services, and parents may receive information from their insurer (EOBs), which COPA cannot control.
- In rare cases, state law also requires COPA to disclose information without consent if necessary to prevent serious harm, as permitted or required by law.
- For integrated behavioral health services, I understand that communication with parents/guardians will follow Oregon minor confidentiality law and clinical judgment when safety concerns exist.

COPA will follow all Oregon confidentiality laws when communicating with minors and parents.

4. Telehealth Services

- I consent to my child receiving healthcare services through telehealth, including audio-only or audio/video communication, when clinically appropriate and offered by the provider. I understand that telehealth may involve the electronic transmission of medical information and images.
- I understand that telehealth has potential benefits and limitations, and that the provider may determine that my child needs an in-person examination, diagnostic testing, follow-up care, or emergency medical services. If the provider recommends in-person care or emergency treatment, I am responsible for seeking care as directed.
- I understand that I am responsible for ensuring that I (and my child, when applicable) participate in the telehealth visit from a private and safe location that supports confidentiality and minimizes interruptions or risks during the visit.
- I may decline telehealth services and request in-person care at any time, except when limited by public health guidance or state law.

5. Consent for Emergency Care

If urgent or emergency care is required and I cannot reasonably be reached, I authorize COPA to act in my child's best interest, including:

- Providing necessary treatment
- Contacting emergency services
- Transferring my child to a hospital or emergency facility
- Sharing relevant medical information with emergency personnel

6. Behavioral Health Services

I understand that if integrated behavioral health services are provided, information will be shared with parents/guardians in compliance with Oregon minor confidentiality laws.

7. Social Needs & Safety Screenings

I consent to COPA conducting age appropriate screenings including developmental, behavioral, mental health, risk, and social-needs assessments, as recommended by pediatric and public health guidelines. These screenings may include questions about family needs, safety, housing, food access, or support. Participation is voluntary, and results are used only to assist with care coordination and resource connections.

8. Use and Disclosure of Health Information

I consent to the use and disclosure of protected health information for purposes of treatment, payment, and healthcare operations, as described in the Notice of Privacy Practices. This may include communication with pharmacies, laboratories, imaging facilities, hospitals, specialists, behavioral and mental health providers, and other healthcare professionals involved in my child's care.

This communication may occur verbally, electronically, or in writing for the purpose of consultation, referral, continuity of care, and care coordination activities.

I acknowledge that I have been offered the Notice of Privacy Practices.

9. Financial Responsibility

I am responsible for charges not covered by insurance. I authorize COPA to bill my insurance and release necessary information for payment. Co-pays and any required parent share are due at the time of service. I understand that my insurance may not cover all services, and coverage is dictated by my plan benefits, not COPA. See Financial Policy.

10. Consent for Clinical Photography (Optional)

I consent to photographs or videos of my child for clinical documentation only, stored within the medical record. These images will not be used for marketing, research, or teaching unless separate written authorization is provided.

11. Patient & Parent/Guardian Rights

I acknowledge I have been offered a copy of Patient & Parent/Guardian Rights and Responsibilities.

12. Consent for Communication, Referrals, and Care Coordination

COPA may coordinate care with hospitals, specialists, therapists, schools, and community programs involved in the child's treatment. Non-treatment disclosures require separate written authorization. COPA may assist families with referrals to community resources, social support, or care coordination services when appropriate.

13. Consent to Electronic Communication

I understand email, text message, patient portal messaging, and other electronic communication may be used for appointment reminders, care coordination, or communication related to treatment. COPA uses reasonable safeguards. I understand electronic communication carries inherent privacy risks.

14. Custody, Contact, and Accuracy of Information

I agree to provide accurate demographic, custody, and insurance information and to notify COPA of any changes. COPA may rely on the information provided unless updated in writing.

15. Acknowledgment of Notice of Privacy Practices

I acknowledge COPA's Notice of Privacy Practices (NPP) has been made available to me. I understand it describes how COPA may use and disclose health information and my rights under federal law.

15. Right to Withdraw Consent

I understand I may withdraw this consent in writing at any time, except to the extent services have already been provided. Withdrawal will apply to future care only and does not require COPA to reverse actions, disclosures, or billing already completed.

Signature

Print Name: Date:

Relationship to patient:

Patient or Parent/Legal Representative Signature: