Request to Receive Family Planning Services

Name: _____ Chart No. _____

CONSENT TO SERVICES

I consent to receiving medical and related services from staff of **Richland County Family Planning**. I understand these services may include: health information, education and counseling; review of medical history; medical exam; health screenings such as screenings for cervical and breast cancer, hepatitis C and sexually transmitted diseases including HIV/AIDS, mental health assessments, risk screenings; and referrals. I understand that I will be provided information about the test(s), procedure(s), treatment(s), and family planning method(s) prior to any of these services being provided. I understand I should ask questions about anything I do not understand.

LANGUAGE INTERPRETATION

I understand that I have the right to receive free language interpreter services. I must tell the staff if these services will be helpful to my understanding of the written or spoken information given during my visits.

VOLUNTARY PARTICIPATION

I understand that my receipt of family planning services is voluntary. I can change my mind about receiving these services at any time. I know that my acceptance of Family Planning services is not a prerequisite for the receipt of other services offered at this site.

CLIENT NONDISCRIMINATION

I understand that I am eligible to receive services from this Family Planning clinic without discrimination based on my religion, race, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies, marital status or inability to pay.

CONFIDENTIALITY AND LIMITATIONS

I understand that my medical services and records will receive confidential treatment. My medical records can be disclosed to others only with my written consent, or as otherwise required by law such as reporting child abuse and neglect. If tests are taken for any sexually transmitted diseases, reporting of positive results from those tests to public health agencies is required by law. If my insurance is billed for my visit, some health information could be shared with the insurance policy holder. I can request that my insurance not be billed for certain services or visits if I am concerned about the policy holder learning that I received services.

NOTICE OF PRIVACY PRACTICES

My signature on this form indicates that I have received or been offered a copy of the Notice of Privacy Practices. I understand that I may request a copy of the Privacy Notice at any time.

FINANCIAL RESPONSIBILIY AND AUTHORIZATION FOR RELEASE OF INFORMATION

If my visit is covered by insurance or other third-party payers, I authorize **Richland County Family Planning** to release medical information necessary to determine benefits payable under this claim and I authorize payment of medical benefits to the physician or supplier of services rendered. I understand I am financially responsible for this bill according to my pay category regardless of insurance coverage. I hereby certify that I have read and understand the above and voluntarily consent for the services and supplies provided by this clinic.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____