Place Patient Label Here

North Carolina Department of Health and Human Services
Division of Public Health
Women, Infant and Community Wellness Section
Reproductive Health Branch

Family Planning
General Consent for Services

I agree to be a patient: I am choosing to become a patient and receive services from the Family Planning Clinic of my own free will and I understand that I have the right to accept or refuse family planning services without being denied other services from this agency. I hereby consent to services that may include:

- A physical exam
- Lab tests (which may include screening for syphilis, HIV, gonorrhea, chlamydia, cervical cancer)
- Birth control supplies and education
- Treatments and tests that are agreed upon by myself and my health care provider

Confidentiality (Private): I know that my medical information is private and is protected by state and federal confidentiality laws. Staff will not share this information unless:

- I tell the staff in writing that they can share it
- It is an abnormal test result that needs to be shared with a health care provider at another clinic or agency to provide my follow-up care
- It is shared for treatment, payment or health care operations, as explained in the Notice of Privacy Practices
  - An example of sharing for treatment is communicating with other clinics you go to about your care
  - An example of sharing for payment is billing your Medicaid or health insurance plan for services
  - An example of sharing for health care operations is medical records reviews by state auditors
- It is required by law
- If you are under age 18, your information will not be shared with your parent or guardian without your permission, unless your health care provider thinks that sharing the information is absolutely necessary for your life or health. In this case, your health care provider will contact you before sharing information, unless it is an emergency or you cannot be reached.

Follow up: I know that if any problems are found, suggestions will be made to me concerning follow-up and it is up to me to follow up. I will let the Health Department know of any changes to my address and/or telephone number so that I may be contacted quickly, if needed. If my exam or lab work shows any problems, staff may send me to another clinic for help, if needed.

Consent for Contraceptive Method: I understand that I will receive education and counseling on the risks and benefits of available contraceptive methods. My medical provider and I will discuss the methods that best meet my needs and preferences. I recognize that all birth control methods have both risks and benefits. I accept responsibility for ensuring that I understand these risks and benefits and for accepting the risks associated with my chosen method when I decide to start using it.

_____ ____/____/____

Signature of Patient Date

INTERPRETER'S STATEMENT

If an interpreter is provided to assist communication between the provider and the patient regarding the patient's choice of a birth control method:

I have translated the information and advice presented orally to the patient to use the above contraception by the person obtaining this consent. I have also read the consent form to the patient in _____ language and explained its contents. To the best of my knowledge and belief, the patient understood this explanation.

_____ ____/____/____

Interpreter Date