UNION COUNTY HEALTH DEPARTMENT

REPRODUCTIVE HEALTH AND WELLNESS PROGRAM

CONSENT FOR MEDICAL SERVICES

Name: _____ Date of Birth: _____

I give my consent to the clinical staff of the above named clinic to examine, treat and counsel me. I understand and agree with the following:

Services

It is my choice whether or not to receive services and I can change my mind about receiving services at this clinic at any time. Receiving family planning services is not a requirement to receiving any other services offered at the clinic, assistance from, or participation in any other program that is offered at the Union County Health Department (UCHD).

Family planning services may include: review of my health history, physical examination, routine family planning visits, contraception, sexually transmitted infection and HIV screening and testing (if indicated) and risk reduction counseling, pregnancy testing and counseling, preconception screening and counseling, and referral for care not provided at this clinic. My provider might recommend lab tests if needed. I will be provided information about the test(s), procedure(s), treatment(s) and birth control methods(s) prior to any of these services being provided. This information will include the benefits, risks, possible problems or complications and other options. I will ask questions about anything I do not understand. No guarantee is given to me as to the results of any services I receive.

I may be given referrals for further diagnosis or treatment when necessary. I understand that if a referral is needed, I will assume responsibility for obtaining and paying for this care.

I understand that a clinician is available to answer questions I may have today or during normal business hours. For questions or concerns related to the care received through UCHD clinic services, I will call the Union County Health Department at 937-642-2053, or toll-free for long distance at 888-333-9461.

In an emergency, I have been advised to call 911 or go to the nearest emergency department. For urgent needs beyond clinic hours, I may consult a regular medical provider, go to an urgent care, or go to an emergency department.

Payment

There are certain hazards and risks connected with all forms of medical care and treatment that may result in additional costs to me (the client). There is no guarantee of payment by insurance or by an assistance program for any costs that the family planning program does not cover and for which I am responsible. I may be billed for non-Title X services. Some lab tests may not be paid for by the family planning program. My provider will discuss these with me.

Privacy

All information about me is kept in strictest confidence and will not be released to anyone without my permission, except as required by law. This could include:

- Positive test results of some sexually transmitted infections
- Sexual or physical abuse of minors
- Physical signs of domestic violence or intimate partner violence

I understand that this health care clinic uses a statewide database that makes my health information available to the Ohio Department of Health for program reporting purposes.

I have been offered a copy of the Union County Health Department (UCHD) Notice of Privacy Practices for more complete details about the ways information may be used.

I have read the above information. It has been explained to me and I understand it. My questions have been answered by a person from the clinic.

_____ _____

Signature of client Date