

**8.16 SAMPLE GENERAL CONSENT FORM****Request to Receive Family Planning Services**

Name: \_\_\_\_\_ Chart No. \_\_\_\_\_

I hereby consent to receiving medical and related services from staff of (CLINIC NAME). 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 behavior screenings; and referrals for care not provided by the program.

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

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 this information will include the benefits, risks, possible problems or complications, and alternate choices. I understand I should ask questions about anything I do not understand.

I understand that my receipt of family planning services is voluntary. I can change my mind about receiving these services at any time. No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that my acceptance of Family Planning services are not a prerequisite for the receipt of other services offered at this site.

I understand that I am eligible to receive services from this Family Planning clinic regardless of my religion, race, color, national origin, disability, age, sex, number of pregnancies, marital status or inability to pay. I also 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. I understand my Family Planning medical records may be shared with other Family Planning clinics for care at other Family Planning clinics of my choice.

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.

If my visit is covered by insurance or other third-party payers, I authorize (CLINIC NAME) to release medical information necessary to determine benefits payable under this claim. 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: \_\_\_\_\_