

FAMILY PLANNING PROGRAM CONSENT FORM



Name: _____ Birth date: _____

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

- Family planning services may include: review of my health history, routine family planning visits to start a birth control method, 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.
- 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 choices. I will ask questions about anything I do not understand.
- 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.
- No guarantee is given to me as to the results of any services I receive.
- I agree to a physical exam, including a breast exam and pelvic or genital exam, if one is recommended.
- My provider might recommend lab tests, including a Pap test, if needed.
- I may be referred to another health care provider for further testing or treatment if necessary.
- Receiving family planning services is not a requirement to receiving any other services offered at the clinic.

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 aid program for any costs that the family planning program does not cover and for which I am responsible.
- I may be billed for non-State of Colorado Family Planning Program services including, but not limited to, colposcopy or treating complications resulting from State of Colorado Family Planning Program-covered procedures or side effects from medications.
- Some lab tests may not be paid for by the family planning program. My provider will discuss these with me.
- If I need a referral to another health care provider, I will assume responsibility for getting and paying for this care.

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 diseases
 - 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 Colorado state health department for program reporting purposes.

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

The client received the above information and I believe they understand it.

Signature of staff

Date

Interpreter identification information _____

CDPHE-FPP • REVISED 11-2019