



NORTH DAKOTA DEPARTMENT OF HEALTH
Family Planning Program

REQUEST TO RECEIVE
FAMILY PLANNING SCREENING SERVICES

Name _____ Chart No: _____

I hereby consent to receiving medical and related services from staff of the North Dakota Family Planning (NDFP) Program. I understand these services may include: health education; review of medical history; medical exam; screening for cervical cancer and sexually transmitted diseases including HIV/AIDS; 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 contraceptive 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 know that it is my choice whether or not to receive any of these services. I know that at any time, I can change my mind about receiving services through North Dakota Family Planning. 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, or marital status.

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 reporting certain diseases. 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 North Dakota Family Planning clinics for care at other Family Planning clinics of my choice.

If my visit is covered by insurance or other third party payers, I authorize NDFP 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

Family Planning Staff Witness

Date