Central Montana Family Planning
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(406) 535-8811 phone & fax
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REQUEST FOR MEDICAL SERVICES
&
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

NAME: _____ **DOB:** _____ **PATIENT #:**_____

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

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 of spoken information given during my healthcare visits.

I have been given information about the test(s), treatment(s), procedure(s), contraceptive method(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Central Montana Family Planning.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if a referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in Central Montana Family Planning's *Notice of Health Information Privacy Practices (HIPAA)*. I consent to the use and disclosure of my health information as described in the *Notice of Health Information Privacy Practices*.

For Title X Patients receiving contraceptive services on a sliding fee scale without an exam:
I understand that I can receive 3 months of hormonal contraceptives and defer having a physical exam based on information I provide about my medical history, family history, blood pressure, and weight. I agree to request records of an exam done in the last 12 months (breast, pelvic, and Pap smear) or will schedule to have an exam at this clinic as soon as possible. Future exams must be done at this clinic to receive Title X services. I realize that postponing an exam may delay a diagnosis of an infection or condition that might exist now.

I hereby request that a person authorized by Central Montana Family Planning provide appropriate evaluation, testing, and treatment (including a birth control drug or devise, if I request it). I hereby acknowledge receipt of Central Montana Family Planning's *Notice of Health Information Privacy Practices*.

Patient Signature:_____ **(Valid for 12 months from signature)** **Date:** _____

I hereby witness the fact that the patient received the above mentioned information and said s/he read and understood same and had the opportunity to ask questions.

Witness Signature:_____ **Date:** _____

☐ CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW

Signature of any other Person Consenting: _____ Date: _____
Relationship to Patient:
_____

I witness the fact that the Patient's Legal Guardian (or person consenting in her/his behalf) received the above mentioned information and said s/he read and understood same.
Witness Signature: _____ Date: _____