

CLIENT INFORMATION AND
INFORMED CONSENT FORM

CHART #: _____

NAME: _____ Birthdate: _____

STREET ADDRESS: _____ APARTMENT NUMBER: _____

CITY: _____ STATE _____ ZIP CODE: _____

HOME PHONE #: _____ CELL PHONE # _____ WORK PHONE#: _____

EMPLOYER: _____ SOCIAL SECURITY #: _____

NAME OF SCHOOL IF YOU ARE A STUDENT: _____

CIRCLE ONE: SINGLE MARRIED LIVING TOGETHER SEPARATED DIVORCED WIDOW

CIRCLE ONE OR MORE: WHITE AMERICAN INDIAN BLACK ASIAN PACIFIC ISLANDER

ARE YOU HISPANIC? YES NO

IF THIS IS YOUR FIRST VISIT, HOW DID YOU HEAR ABOUT US? (CIRCLE ONE) OTHER FAMILY PLANNING CLINIC HOSPITAL
PRIVATE DOCTOR SCHOOL OTHER PATIENT FAMILY/FRIEND BRIGHT START/BABY CARE DSS/MEDICAID WIC
RADIO INTERNET YELLOW PAGE NEWSPAPER SELF SOCIAL AGENCY/CHURCH

PLEASE CHECK ALL THE WAYS WE MAY CONTACT YOU

CALL HOME ___ CALL WORK ___ CALL CELL ___ TEXT MESSAGE ___ CARRIER _____

E-MAIL ___ ADDRESS _____ MAIL (RETURN ADDRESS) ___ MAIL (PLAIN ENVELOPE) ___

LEAVE MESSAGE WITH _____ PHONE #: _____ RELATIONSHIP: _____

LEAVE MESSAGE ON ANSWERING MACHINE YES ___ NO ___

PLEASE LIST WHO TO CONTACT IN CASE OF EMERGENCY (MUST BE PARENT OR GUARDIAN IF UNDER 18)

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

17 OR YOUNGER – HAVE YOU EVER TALKED WITH YOUR PARENT, GUARDIAN, OR OTHER ADULT MEMBER ABOUT WHETHER
OR NOT TO HAVE SEX? YES ___ NO ___

DO YOUR PARENTS/GUARDIAN KNOW THAT YOU ARE COMING TO FAMILY PLANNING? YES ___ NO ___

INSURANCE INFORMATION AND/OR MEDICAID NUMBER:

DO YOU HAVE HEALTH INSURANCE? YES ___ NO ___

DUE TO CONFIDENTIALITY, I REQUEST THAT INSURANCE NOT BE USED. ____

INSURANCE/MEDICAID NUMBER: _____ PRIMARY CARE PHYSICIAN: _____

POLICYHOLDER: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

STREET OR PO BOX CITY STATE ZIP

BIRTHDATE _____ POLICYHOLDER EMPLOYER: _____

COMPANY NAME: _____ POLICY#: _____ GROUP#: _____

ADDRESS: _____

STREET OR PO BOX CITY STATE ZIP

INFORMED CONSENT FOR FAMILY PLANNING SERVICES

I hereby consent to receiving medical and related services from staff of the South Dakota Family Planning 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 South Dakota Family Planning. No guarantee has been given to me as to the results that may be obtained from any services I receive.

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 South 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 SDFP 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. This release of medical records information is valid for a period of one year from the date I sign this document

I hereby certify that I have read and understand the above consent.

Signature of Client _____ Date _____

Signature of Witness _____ Date _____

FOR OFFICE USE ONLY

Family Size: _____ Monthly Income: _____

Pay Category: _____ Expiration Date: _____

Proof of Income: Pay stubs _____ Income Tax Return _____ Other _____

Staff Signature: _____ Date: _____

FOR OFFICE USE ONLY

Family Size: _____ Monthly Income: _____

Pay Category: _____ Expiration Date: _____

Proof of Income: Pay stubs _____ Income Tax Return _____ Other _____

Staff Signature: _____ Date: _____