Family Planning Program Consent
TCHD Family Planning

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 anther 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-Title X services including, but not limited to, colposcopy or treating complications resulting from Title X-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

Label

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

____ ____________________

Signature of staff Date

Interpreter identification information ________________________

Informed Consent for Telehealth Services

Client Name: ________________________________ Date of Birth: ___________
(*Please Print*)

Tri-County Health Department (TCHD) acknowledges there are situations when a client cannot be visited with or seen in-person, and services can be provided via a method other than in-person.

Telehealth involves the use of electronic communications to enable providers to deliver healthcare services remotely as an extension of client encounters with the purpose of maintaining the continuum of care.

I understand and agree to the following: (Please Initial)

_______ I understand that occasional telehealth visits (by phone or other TCHD approved technology) are an alternative way for me to receive program services. understand that complete privacy and/or security is not guaranteed in telehealth visits, and this has been discussed with me. I further understand that telehealth visits are optional and that I may decline telehealth visits at any time.

☐ Yes, I would like to participate in the telehealth option of the program.

☐ No, I would not like to participate in the telehealth option of the program.

____ _____________________
Signature of Client/Legal Guardian Date

Consent form explained by: ___________________________, TCHD Staff ________
Date