HAYWOOD COUNTY HEALTH AND HUMAN SERVICES AGENCY
PUBLIC HEALTH SERVICES DIVISION

Consent for Services

I, (please print PATIENT name and Date of Birth) _____
choose to become a patient and receive services at Haywood County Health and Human Services Agency, Public Health Services Division, of my own free will. I hereby give consent to services requested/referred by self, parent, legal guardian or my health care provider which may include the following:

* Complete/Limited Physical Exam with a wellness focus.
  Haywood County Health and Human Services Agency Public Health Services Division is not to be considered as your primary health care provider. Practitioners may be able to treat minor acute problems, but any chronic health conditions identified through the health assessment will be referred to your primary care provider for review and follow-up. Haywood County Health and Human Services will release information regarding the services you receive to your primary health care provider with your signed permission.
* Lab tests (which may include Sexually Transmitted Infection screenings such as HIV, Gonorrhea, Chlamydia, HPV, Syphilis and other tests)
* Birth Control supplies and education
* Immunizations
* Counseling on disease(s) transmission, diagnoses and treatments including taking appropriate treatment and encouraging sex partner to also.
* Other Tests (as may be indicated)
* Child Health Clinic provides physical assessments (check-ups), vision, hearing, developmental/mental health screenings, referral and follow-up care as well as treatment of common childhood illnesses. (See page 2 for minors' consent for Family Planning Services)

I have been given specific information on the benefits and risks of the recommended treatment and/or screening tests pertinent to my requested services along with information on safety, effectiveness, potential side effects, complications and danger signs; as well as possible alternatives have been presented.

I have been counseled and provided information related to the requested services and understood the content. I am aware that I may decline the screening tests, physical exam, treatment or referrals that may be recommended.

Receipt of family planning services is not a prerequisite to receipt of any other services offered in the Haywood County Health and Human Services Agency.

I know that if any problems are found, suggestions will be made concerning follow up and it is up to me to follow-up. I will let the agency know of any changes in my address and/or telephone number so that I may be contacted quickly by staff, if needed. If my exam or lab work identifies any problems, staff may refer me to another clinic or provider for help and my records will faxed to the referring provider or clinic.

I will receive counseling that I should use a latex condom if I (or partner) have sex with more than one partner to prevent the spread of a sexually transmitted disease, including HIV that causes AIDS. I understand that few people have reactions to latex condoms. If I get a rash or have other problems, I will stop using them and call the Health and Human Services Public Health Services Division for further instructions.

Patient Name: _____ Date of Birth: _____

My medical information is strictly private and is protected by North Carolina law 130A-143, federal regulations of HIPPA and confidentiality of Alcohol and Drug Abuse Patient Records - 42 CFR Part 2. Staff will not share or send this information to anyone unless:

- I tell staff in writing that they can share it
- Staff needs the information to provide services at this clinic
- It is required by law

I acknowledge that this consent is voluntary. I understand I may rescind this consent at any time by written notification, except to the extent that action has already been taken, and a copy of "Notice of Privacy Practices" has been made available to me.

If I am under 18 years of age, I understand that I may have family planning services without the permission of my parents. Staff has promised me that services are private and, if follow up is needed, every attempt will be made to assure my privacy. I will be reached and informed of the need for my parent(s) to be notified if follow up is needed. Staff will talk to me about the importance of my discussing birth control needs with my parent(s). <u>I understand that staff are also available to talk to me about how I can keep other people from forcing me to have sex.</u>

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☐ *The Haywood County Health and Human Services Agency Public Health Services Division will file most insurances as a courtesy to the patient; however, this is not a guarantee of payment. I understand that I am responsible for paying the remaining balance.*

_____ ____/____/____
Signature of Patient / Parent / Legal Guardian Date

_____
Printed Name of Patient / Parent / Legal Guardian

Interpreter's Statement

If an interpreter is provided to assist the individual with services, i.e., choosing a birth control method: I have translated the information and advice presented orally to the individual obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to her. To the best of my knowledge and belief, he/she understood this explanation.

_____ ___/___/___
Interpreter Date

In Case of Emergency – Call HCHHSA Public Health Services Division at 452-6675 and after hours, call 911

Haywood County HHSA is an equal opportunity provider and employer