



Family Planning Association of Chelan-Douglas Counties

900 Ferry Street, Wenatchee, WA 98801 • (509) 662-2013

GENERAL CONSENT FOR SERVICES

I hereby request and authorize Family Planning to provide healthcare services available and deemed necessary by the clinic staff. These services may include, but are not limited to, evaluation of my medical and family history, physical examination (weight, blood pressure, breast and pelvic examination), laboratory tests (urine, Pap smear, STI screening, including HIV, blood tests), medications or prescriptions, injections and minor surgical procedures. I understand that no test is perfect and all tests may fail to detect a problem (i.e. 'false negative'). I understand staff will explain recommended services and procedures and that I have a right to ask questions about my care and any recommended services.

I understand I have a right to refuse any procedures or services that are recommended. Refusing some types of care will not jeopardize my receiving appropriate care for other problems or concerns.

It is my responsibility to give as complete and accurate medical history as possible. If new problems that may be related to my condition or care arise, I understand that I should inform Family Planning. I understand that it is my responsibility to get testing or care beyond that provided by Family Planning when staff deems a referral is necessary.

I understand that services provided at this clinic and any personal information with staff is strictly confidential within the confines of the law. This means that, in general, information may not be revealed to others without my specific written permission. **There are exceptions, which are described below:**

I understand that I will be advised if any of the following exceptions apply:

- *Certain sexually transmitted infections (STIs) are required by law to be reported to the State Department of Health for public health statistics and follow-up.**
- *If staff has reason to believe I present an immediate threat of harm to myself or others.**
- *If there is reason to believe that child abuse has or is occurring, a report to Law Enforcement or Child Protective Services is made. **
- *If insurance or a third party payer is used to assist in paying for services, they may require detailed information including a summary of medical history, laboratory or diagnostic tests, information about HIV/AIDS, STIs, drug/alcohol abuse, mental illness or mental health issues.*

Client Signature

Date

Counselor Signature

Date