

Place Client Label Here

**Registration Sheet** Please make sure that you fill in this form correctly and completely.

LAST NAME		FIRST NAME		MI	DATE OF BIRTH	
MAILING ADDRESS		APT #	CITY	COUNTY	STATE	ZIP CODE
<b>Can we contact you at the address listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No</b>						
If NO, please provide an alternative address. C/O (Name)				ALTERNATIVE ADDRESS		
HOME PHONE ( )		WORK PHONE ( )		CELL PHONE ( )		
Can we contact you at home? <input type="checkbox"/> Yes <input type="checkbox"/> No		Can we contact you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Can we contact you on your cell? <input type="checkbox"/> Yes <input type="checkbox"/> No		
E-MAIL ADDRESS				Can we e-mail you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
* We will not sell or distribute your e-mail address to anyone else				* If yes, please complete back of form		

**Contact Information & Instructions**

The information below will be used by Planned Parenthood (PP) when we need to contact you with an abnormal test result, or to remind you about (or reschedule) your appointment, or to send a monthly bill if you have an outstanding balance. Please be aware that **if you do not answer our calls or mail regarding an abnormal test, we will attempt to reach you through your emergency contact below.**

*I understand that PP will never give medical information to anyone but me without my consent, so when calling me, PP can:*

<input type="checkbox"/> Identify themselves as Planned Parenthood		<input type="checkbox"/> Identify themselves only as my "doctor's office"	
<input type="checkbox"/> Use a code name of _____ to leave a message for me to return the call; I understand that when I receive a message under this name that I must call Planned Parenthood.			
<b>Who should we contact in case of an emergency?</b>			
Name: _____		Phone: _____	
Relationship: _____			
TODAY'S DATE		YOUR AGE	YOUR SEX <input type="checkbox"/> Female <input type="checkbox"/> Male
YOUR WEEKLY INCOME		YOUR FAMILY SIZE (including yourself)	
YOUR RACE <input type="checkbox"/> Caucasian (W) <input type="checkbox"/> Black (African-American) <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Alaskan Native/American Indian		YOUR ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	
HIGHEST GRADE COMPLETED	ARE YOU A STUDENT NOW? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Part time <input type="checkbox"/> Full time	NUMBER OF LIVING CHILDREN (Born to you)
DO YOU CURRENTLY USE CONDOMS? <input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never		DO YOU CURRENTLY USE A BIRTH CONTROL METHOD? <input type="checkbox"/> Yes <input type="checkbox"/> No	WHAT METHOD?

<b><u>OFFICE USE ONLY:</u></b>			
Reviewed by _____	Date _____	Reviewed by _____	Date _____
Reviewed by _____	Date _____	Reviewed by _____	Date _____

**AUTHORIZATION FORM FOR USE OF E-MAIL COMMUNICATIONS  
SCOPE OF PERMITTED E-MAIL COMMUNICATIONS**

**I HEREBY AUTHORIZE PP OF NORTHEAST OHIO TO USE THE ABOVE E-MAIL ADDRESS TO COMMUNICATE WITH ME FOR THE FOLLOWING LIMITED PURPOSES:**

- Send me appointment reminders
- Direct me to its website for forms or information prior to an appointment
- Ask me to phone the health center for additional information

I agree that use of e-mail communications will be limited to the purposes checked above and I will not use e-mail to communicate with PP of Northeast Ohio for any other purposes. **Under no circumstances will I use e-mail communications for urgent or emergency issues.** I further understand that e-mail messages are checked only on a limited basis and only during normal business hours.

I understand that the e-mail communications from PP of Northeast Ohio may contain some or all of the following information:

- o My Name, My Date of Birth, PP of Northeast Ohio Clinic name, location and phone number
- o Provider/Clinician name, Date and Time of Appointment

When I e-mail PP of Northeast Ohio, I will:

- o Put the reason for the message in the subject line of the e-mail.
- o Put my name and date of birth in the message.
- o Write my message short and to the point.

When I receive an e-mail message from PP of Northeast Ohio, I will use the reply feature on my computer to let acknowledge that I have received the message.

**RISKS OF E-MAIL COMMUNICATIONS**

E-mail communications are not reliable, secure or private. For example:

- E-mail messages can be intercepted by or subject to unauthorized access (i.e., hacking).
- E-mail messages may be misdirected, lost, or otherwise subject to transmission errors.
- E-mail messages may be from someone other than the named sender and are easier to forge than handwritten, signed papers.
- Anyone with access (whether authorized or obtained through improper means) to an e-mail account will have access to all messages in that e-mail account.
- Anyone with that receives or has access (whether authorized or obtained through improper means) to an e-mail message will be able to read, forward, copy, delete or otherwise manipulate the e-mail messages.
- E-mail messages cannot really be deleted.
- E-mail services have a right to save and check e-mail sent through their system.
- E-mail can spread viruses.

Without limiting the foregoing, I acknowledge and accept that e-mail communications sent pursuant to this Authorization will be sent from PP of Northeast Ohio and anyone that receives or has access to that e-mail will know that the message is from PP of Northeast Ohio and will be able to view the content of that e-mail.

This Authorization is made for the following purpose:

- At my request, OR
- Specify: \_\_\_\_\_

**CONDITIONS OF AUTHORIZATION**

1. I have read and agree to agree the Scope of Permitted E-mail Communications set forth above.
2. I have read and accept the Risks of E-mail Communications set forth above.
3. This Authorization will expire on (insert date or event): When revoked.
4. I may revoke this Authorization at any time by notifying PP of Northeast Ohio in writing, and it will be effective on the date notified except to the extent that PP of Northeast Ohio has already acted upon such Authorization.
5. Communications made pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.
6. By authorizing use of e-mail communications, my healthcare and payment for my healthcare will not be affected if I do not sign this Authorization form.
7. I have been offered a copy of this signed Authorization form.
8. I agree to release PP of Northeast Ohio from and hold PP of Northeast Ohio harmless for any liability that may arise as a result of or in connection with the use of e-mail technology in the context of my relationship with PP of Northeast Ohio, including but not limited to breaches of confidentiality or privacy arising the use of e-mail technology.

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE

OR \_\_\_\_\_  
PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE