

REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION
 PRIVACY PRACTICES
 Planned Parenthood of Montana

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Planned Parenthood may need to refer me to another health care facility to provide the services necessary for my care.

I understand that the information I will provide is true, accurate, and complete and that my healthcare choices will depend on that information.

I will be given information about the test(s), treatment(s), procedure(s), and contraceptive method(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Planned Parenthood.

I understand that Title X family planning services are available and it is my choice whether or not to have these services. I understand that I do not need to receive Title X family planning services to receive other services offered by this clinic.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I understand that if I have an abnormal test result, the verbal or written communication I receive will include the following: an explanation and meaning of the abnormal finding and the possible consequences of not receiving additional care and/or treatment if needed.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I will be told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in Planned Parenthood of Montana's *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.

I understand that some applicable services (those not requiring a physical exam) may be delivered via telemedicine and, if so, that I will not be in the physical presence of a clinician. Should this be the case, I understand that I have the right to request that my appointment be rescheduled to a time and place where a clinician will be in my physical presence to

100 W. Wicks Lane Billings MT 59105 406-869-5040	1844 Broadwater Ave Billings MT 59102 406-656-9980	211 9 th Street South Great Falls MT 59405 406-454-3431	1500 Cannon St Helena MT 59601 406-443-7676	219 East Main Missoula MT 59802 406-728-5490	After Hours for all clinics: 1-888-867-8961
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provide services. Should I choose to receive care via telemedicine, I understand that I am also agreeing to receive messages from Planned Parenthood through privacy-protected secure messages within the telemedicine app or website. I understand I can enable notifications in the telemedicine app and/or website account settings to alert me when I have a message. The notifications do not contain any protected health information.

Please note that Planned Parenthood of Montana is a teaching institution, and that persons in training, under strict supervision, may be involved in some aspects of your care.

I hereby request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

I hereby acknowledge receipt of Planned Parenthood of Montana’s notice of health information privacy practices.

Signature of patient _____ Date _____

I witness that the patient received the above mentioned information, said it was read and understood, and had the opportunity to ask questions.

Signature of witness _____ Date _____

	CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW
Signature of any other person consenting _____	
Relationship to patient _____	
Date _____	
I witness the fact that the patient's legal guardian (or person consenting on the patient’s behalf) received the above mentioned information and said it was read and understood.	
Signature of witness _____	
Date _____	

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