1. Last Name	First Name	MI
2. Patient Number		
3. Date of Birth (MM/DD/YYYY)	Month / Day / Year	
4. Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ White		
5. Ethnic Origin ☐ Hispanic Cuban ☐ Hispanic Mexican American ☐ Hispanic Other ☐ Hispanic Puerto Rican ☐ Not Hispanic/Latino ☐ Unreported		
6. Gender ☐ Female ☐ Male		
7. County of Residence		

N.C. Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section
Family Planning and Reproductive Health Unit

Family Planning
General Consent for Services

I agree to be a patient: I am choosing to become a patient and get services from the Family Planning Clinic of my own free will. I hereby consent to services that may include:

- A complete exam
- Lab tests (which may include screening for syphilis, HIV, gonorrhea, chlamydia, cervical cancer)
- Birth control supplies and education
- Treatments and tests which are felt needed by the healthcare provider

Confidentiality (Private): I know that my medical information is strictly private and is protected by North Carolina law 130A-143. Staff will not share or send this information to anyone unless:

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

Follow up: I know that if any problems are found, suggestions will be made to me concerning follow up and it is up to me to follow up. I will let the Health Department know of any changes in my address and/or telephone number so that I may be contacted quickly, if needed. If my exam or lab work shows any problems, staff may send me to another clinic for help, if needed.

_____ _____/_____/_____
Signature of Patient Date

_____ _____/_____/_____
Signature of Patient Date

_____ _____/_____/_____
Signature of Patient Date

_____ _____/_____/_____
Signature of Patient Date

Age: If I am under 18 years of age:
I understand that I may get 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). **I understand that staff are also available to talk to me about how I can keep other people from forcing me to have sex.**

_____ _____/_____/_____
Signature of Patient Date

_____ _____/_____/_____
Signature of Patient Date

_____ _____/_____/_____
Signature of Patient Date

_____ _____/_____/_____
Signature of Patient Date

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual in choosing her birth control method:

I have translated the information and advice presented orally to the individual to use the above contraception by the person obtaining this consent. I have also read her the consent form in _____ language and explained its contents to her. To the best of my knowledge and belief, she understood this explanation.

_____ _____/_____/_____
Interpreter Date

_____ _____/_____/_____
Interpreter Date

_____ _____/_____/_____
Interpreter Date

_____ _____/_____/_____
Interpreter Date