WEST VIRGINIA DEPARTMENT OF HEALTH
BUREAU FOR PUBLIC HEALTH
OFFICE OF MATERNAL, CHILD, AND FAMILY HEALTH
DIVISION OF WOMEN'S AND FAMILY HEALTH
FAMILY PLANNING PROGRAM

PATIENT INFORMATION FORM

Please note: This facility is a provider for the WV Family Planning Program, a Title X entity. Income, family size, and contact information are required to be collected for all patients. If you would like more information about the Title X WV Family Planning Program or want to know how to access low-cost/free services, ask your provider today!

Last Name: _____ **First Name:** _____

Date: _____ **Telephone No:** _____

Social Security Number: _____ **County:** _____

Address: _____ **City:** _____ **State:** ___ **Zip:** _____

Race: _____ **Last Grade Completed:** _____ **Date of Birth:** _____ **Sex: F** __ **M** __

What type of insurance do you have? (please circle): Private Medicaid None Other: _____
Insurance Company: _____

You should know that insurance companies send out a letter called an Explanation of Benefits or EOB to the insurance policy holder about the health care services you receive at the clinic.

☐ **Check here to let clinic staff know that you do *NOT* want the policy holder to know that you received services at the clinic.**

You have the right to Confidential Services through the WV Family Planning Program. These are services rendered without the involvement of family such as spouses, parents, or guardians.

☐ **Check here to let clinic staff know that you would like to request Confidential Services.**

How do you prefer to be contacted?: ☐ **Phone** ☐ **Mail** ☐ **Text** ☐ **Other (list):** _____

☐ **Do Not Contact Directly (Must specify alternate contact):**

Alternate Contact: Name: _____ **Relationship:** _____

Address: _____ **Telephone No:** _____

Please initial after each section to verify you received information about each of the items listed.

CONSENT FOR SERVICES – Initial _____

- **I understand medical services may include appropriate laboratory testing, physical examination, pap smear, and pelvic examination. I have received counseling and education on the risks and benefits of the medical services I will be receiving and grant permission to have all such medical services and/or treatment procedures as may be deemed necessary in collaboration with authorized personnel of this health facility.**

CONSENT FOR CONTRACEPTIVE METHOD – Initial _____

- **I have received education and counseling on the risks and benefits of all available contraceptive services and methods, including Fertility Awareness-Based Methods and Long-Acting Reversible Contraceptives. I understand the risks and benefits for my method of choice and accept responsibility for the same.**

VOLUNTARY SERVICES – Initial _____

- **I understand that all services provided are voluntary. I voluntarily agree to receive services at a facility that participates in the WV Family Planning Program, a Title X entity. I assert that these services were not presented as a requirement or prerequisite for any other program or service.**

CONFIDENTIALITY – Initial _____

- **I have been informed that this clinic assures patient confidentiality and provides safeguards against the invasion of personal privacy, as required by the Privacy Act of 1974 and Health Insurance, Portability and Accountability Act of 1996 (HIPAA) regulations. All information which may be identified with me will be considered privileged and confidentiality will be maintained.**

COUNSELING AND EDUCATION – Initial _____

- **I understand that I will be offered counseling and education on reproductive health and planning.**
- **If I am 17 or under, I understand I will receive counseling on how to resist coercion into engaging in sexual activity and the benefits of involving family in my decision to seek family planning services.**
- **I have been advised neither family involvement nor parental/guardian notification is a requirement.**

_____ _____
Signature **Date**