**GALLIA COUNTY HEALTH DEPARTMENT CLINIC**

PHONE: 740-441-2958 FAX: 7404412947

* Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Parent/ Guardian Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_
* Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* County of residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Home Phone Number: (\_\_\_) -\_\_\_\_\_\_\_\_\_\_\_
* Cell Phone Number: (\_\_\_) -\_\_\_\_\_\_\_\_\_\_\_
* Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Emergency Contact:
	+ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Phone: (\_\_\_) -\_\_\_\_\_\_\_\_\_\_\_

\*Consent to Call? ☐ YES ☐ NO Text? ☐ YES ☐ NO

* Sex: ☐ Male ☐ Female ☐ Other: \_\_\_\_\_\_\_\_\_\_
* Race: ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ Native American ☐ Biracial ☐ Other (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Ethnicity: ☐ Non-Hispanic ☐ Hispanic Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
* Number of people in your household? \_\_\_\_\_\_\_
* Place of Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Number: (\_\_\_) -\_\_\_\_\_\_\_\_\_\_\_
* How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Preferred Pharmacy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Please complete the table below to the best of your ability.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Household member/Relationship**  | **Source of Income** | **Amount of Income** **(Per week, month or year)** |
| **1.** |  |  |  |
| **2.** |  |  |  |
| **3.** |  |  |  |

**\*Information used for Reproduction Health and Wellness Grant.**

-Do you have private insurance? ☐ YES ☐ NO

-Do you have a medical card? ☐ YES ☐ NO

\*IF YOU HAVE INSURANCE, WE WILL NEED A COPY OF THE INSURANCE CARD.

Initial here if you consent to the Release of Billing Information and Assignment of Benefits related to obtaining payment for this visit, and understand you may receive additional statements for services not covered by your insurance(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If uninsured and being seen through the Reproductive Health & Wellness Program, a sliding fee scale will be used to determine your costs; however, services will not be denied due to an inability to pay.

If uninsured and being seen through the Primary Care Clinic, there will be an office visit fee of $45.00. There will be additional fees for labs, if needed.

\*Are there any financial concerns in the home? ☐ YES ☐ NO

\*Describe the reason for today’s visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Allergies (List anything that you are allergic to: medications, food, bee stings, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **\*MEDICATIONS** Include prescribed and over-the-counter)

|  |  |  |
| --- | --- | --- |
| **DRUG NAME** | **STRENGTH** | **FREQUENCY TAKEN** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |

* Additional meds: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Identify as: ☐Straight ☐ Homosexual ☐Bisexual ☐Transgendered ☐Pansexual ☐Unknown**

**\*Age of current sexual partner: \_\_\_\_\_\_**

**\*Are you here to discuss Birth Control? ☐YES ☐NO**

**\*Are you currently pregnant? ☐YES ☐NO**

**\*Are you trying to become pregnant? ☐YES ☐NO**

**For Women Only**

Date of Last Pap Smear? *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

If menopausal, age at Menopause? \_\_\_\_\_\_\_\_\_\_\_\_\_

HPV Vaccine? ☐YES ☐NO IF YES, HOW MANY? \_\_\_\_\_\_\_\_\_\_\_\_

Sexually Active? ☐YES ☐NO Sexual Problems? ☐YES ☐NO

STIs/ STDs: ☐YES ☐NO If YES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use condoms? ☐ALWAYS ☐SOMETIMES ☐NEVER

Do you have multiple sexual partners? ☐YES ☐NO

Current Birth Control method? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Desired Birth Control method? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Most recent Mammogram? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abnormal PAP? ☐YES ☐NO Do you have a monthly cycle? ☐YES ☐NO

If **YES** when was your last menstrual cycle?­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age of first period? \_\_\_\_\_\_\_\_\_\_\_ Date of last period? \_\_\_\_\_\_\_\_\_\_\_

Total Pregnancies? \_\_\_\_\_\_\_\_\_\_\_ Full Term? \_\_\_\_\_ Premature? \_\_\_\_\_ Ectopic? \_\_\_\_\_\_

Multiple Births? \_\_\_\_\_\_ Living? \_\_\_\_\_\_ Date of Last Birth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you want to have children (more children) someday? ☐YES ☐NO

**For Men Only**

Sexually Active? ☐ YES ☐ NO Sexual Problems? ☐ YES ☐ NO

STIs/ STDs: ☐ YES ☐ NO If YES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use condoms? ☐ALWAYS ☐SOMETIMES ☐NEVER

Do you have multiple sexual partners? ☐ YES ☐ NO

Are you experiencing testicular problems? ☐ YES ☐ NO

Do you perform monthly testicular self-exams? ☐ YES ☐ NO

How many children do you have? \_\_\_\_\_\_\_\_

Do you want to have children (more children) someday? ☐ YES ☐ NO

What is your or your partner’s current birth control method? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a PSA (Prostate) Level in the past? ☐ YES ☐ NO

Prostate Present? ☐ YES ☐ NO

**For Pediatric (Under 18) Patients ONLY**

Are you in Daycare? ☐ YES ☐ NO Name of Daycare: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a student? ☐ YES ☐ NO GRADE: \_\_\_\_\_\_\_\_\_\_

Name of School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who do you live with? (Please circle) Both Parents Mother Father Grandparent Guardian Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents’ Marriage Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many siblings do you have? \_\_\_\_\_\_\_\_\_\_\_\_

Are you involved in sports? If yes, list sports: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Had a lead screening? ☐ YES ☐ NO

Does someone in the household smoke? ☐ YES ☐ NO

Do you see a dentist? ☐ YES ☐ NO

Do you brush your teeth 2 times/day? ☐ YES ☐ NO

Do you experience bullying? ☐ YES ☐ NO

**PAST SURGICAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| **SURGERY** | **REASON** | **YEAR** | **HOSPITAL** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |

**ADDITIONAL HEALTH FACTS**

**Please add other information about your health that you would like your provider to know here:**

|  |
| --- |
|  |

|  |  |
| --- | --- |
|  |  **SIGNIFICANT HEALTH PROBLEMS IN MY FAMILY** |
|  | ALIVE? | AGE | ALCOHOLIC  | ARTHRITIS | DEPRESSION | CANCER | DIABETES | GENETIC DISEASE | HEART DISEASE | HIGH BLOOD PRESSURE | OSTEOPOROSIS | STROKE |
| GRANDMOTHER (MATERNAL) | * Y
* N
 |  |  |  |  |  |  |  |  |  |  |  |
| GRANDFATHER (MATERNAL) | * Y
* N
 |  |  |  |  |  |  |  |  |  |  |  |
| GRANDMOTHER (PATERNAL) | * Y
* N
 |  |  |  |  |  |  |  |  |  |  |  |
| GRANDFATHER (PATERNAL) | * Y
* N
 |  |  |  |  |  |  |  |  |  |  |  |
| FATHER | * Y
* N
 |  |  |  |  |  |  |  |  |  |  |  |
| MOTHER | * Y
* N
 |  |  |  |  |  |  |  |  |  |  |  |
| BROTHER/SISTER | * Y
* N
 |  |  |  |  |  |  |  |  |  |  |  |
| BROTHER/SISTER | * Y
* N
 |  |  |  |  |  |  |  |  |  |  |  |
| OTHER: | * Y
* N
 |  |  |  |  |  |  |  |  |  |  |  |

**PAST MEDICAL HISTORY** (Please check all that apply)

|  |  |
| --- | --- |
| * ADD/ADHD
 | * Gout
 |
| * Acid Reflux (GERD)
 | * Heart Disease
 |
| * Anemia
 | * Heart Problems
 |
| * Anxiety Disorder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Hepatitis
 |
| * Arthritis
 | * High Cholesterol
 |
| * Asthma
 | * History of STI
 |
| * Autoimmune Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * High Blood Pressure
 |
| * Blood diseases: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Overactive Thyroid
 |
| * COPD
 | * Underactive Thyroid
 |
| * Cancer
 | * Infertility
 |
| * Congestive Heart Failure
 | * Kidney Disease
 |
| * Depression
 | * Kidney Stones
 |
| * Dermatologic (Skin) Disorders
 | * Mental Disorder/Illness
 |
| * Diabetes – Type 1
 | * Osteoporosis
 |
| * Diabetes – Type 2
 | * Polyps
 |
| * Diverticulitis
 | * Pulmonary Embolism
 |
| * Ear or Hearing Problems
 | * Seizures/Epilepsy
 |
| * Endometriosis
 | * Stroke
 |
| * GI Problems
 | * Trauma/Violence
 |
| * Blindness
 | * Vision or Eye Problems
 |
| * Other:
 |   |

**SOCIAL HISTORY**

Have you been Vaccinated for COVID? ☐ YES ☐ NO

Which one? \_\_\_\_\_\_\_\_\_ Boosters? \_\_\_\_\_\_\_\_\_\_

Have you been exposed to COVID in the last 10 days that you are aware of? ☐ YES ☐ NO

Have you had a Flu Vaccine this year? ☐ YES ☐ NO

Do you or have you ever smoked tobacco? ☐ YES ☐ NO ☐ QUIT

At what age did you start smoking? \_\_\_\_\_\_\_\_

How much tobacco do you smoke? \_\_\_\_\_\_\_\_\_

Do you vape or use e-cigarettes? ☐Nicotine ☐CBD ☐OTHER Do you use smokeless tobacco? ☐Chew ☐ Snuff ☐Moist Tobacco Powder

What is your level of alcohol consumption? ☐OCCASIONAL ☐MODERATE ☐HEAVY How many years have you consumed alcohol? \_\_\_\_\_\_

Have you used IV drugs? ☐YES ☐NO

Do you currently use recreational or street drugs? ☐YES ☐NO Please List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine Intake: # of cups/cans per day? \_\_\_\_\_\_

Have there been any changes to your family or social situation? ☐YES ☐NO

Do you have any pets? ☐YES ☐NO

Do you have smoke and carbon monoxide detectors in the house? ☐YES ☐NO

Are you passively exposed to smoke? ☐YES ☐NO

Are there any guns present in the home? ☐YES ☐NO

Do you use bug spray? ­­­­☐YES ☐NO Do you use sunscreen? ☐YES ☐NO

Highest grade of school completed \_\_\_\_\_\_

Are you employed? ☐YES ☐NO What is you Occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any occupational health risks where you work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you able to care for yourself? ☐YES ☐NO

Are you blind or do you have serious difficulty seeing? ☐YES ☐NO

Are you deaf or do you have serious difficulty hearing? ☐YES ☐NO

Do you have difficulty concentrating, remembering, or making decisions? ☐YES ☐NO

Do you have difficulty walking or climbing stairs? ☐YES ☐NO

Do you have difficulty dressing or bathing? ☐YES ☐NO

Do you have difficulty doing errands alone? ☐YES ☐NO

Are you able to walk? ☐YES ☐NO

Do you have transportation difficulties? ☐YES ☐NO

Are you or have you been involved with bullying? ☐YES ☐NO

Stress Level? ☐LOW ☐MEDIUM ☐HIGH

Do you wear a helmet? ­­­­☐YES ☐NO Do you use seatbelts? ☐YES ☐NO

Diet: (Please circle) ☐Regular ☐Vegetarian ☐Vegan ☐Diabetic ☐Gluten Free

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise Level? ☐NONE ☐OCCASIONAL ☐MODERATE ☐HIGH

Do you have and advance directive? ☐ YES ☐ NO

Do you have a good support system? ☐ YES ☐ NO

Do you experience emotional/relationship problems? ☐ YES ☐ NO

Is there anyone who often says hurtful/mean things? ☐ YES ☐ NO

Is there anyone who is physically abusive? ☐ YES ☐ NO

If in the past, are you safe now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with depression or other mental health condition? ☐ YES ☐ NO

Do you ever have thoughts of hurting yourself or others? ☐ YES ☐ NO

Do you feel safe in your home? ☐ YES ☐ NO

**Is there anything else you would like the provider to know?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank you for choosing us for your Healthcare needs. Please let us know if you have any suggestions or concerns that would help us improve your Quality of Care:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE SIGN**

X

|  |  |  |
| --- | --- | --- |
| **Signature of patient or legal guardian** |  | **DATE** |

**GALLIA COUNTY HEALTH DEPARTMENT**

**PRIMARY CARE / REPRODUCTIVE HEALTH & WELLNESS CLINIC**

 **Consent for the Provision of Medical Services and to Obtain and/or Release Records HIPPA**

**NAME OF PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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. As a state/federally supported program, the Reproductive Health and Wellness Program is required to provide data to the Ohio Department of Health about the clients we serve and our clinic activities.

I have been given information about the test(s), treatment(s), procedure(s), to be provided including the benefits, risks, possible problem/complications and alternative 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 and services are received on a voluntary basis. I know that I can change my mind at any time. Receipt of family planning services is not a prerequisite of any other services offered.

Services will be provided in a confidential manner; however, 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 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 have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as much as legally possible. A copy of the **HIPPA** guidelines will be provided to me at my request.

I hereby request that a person authorized by the Gallia County Health Department provide appropriate evaluation, testing, treatment (including birth control drug, if I request it).

I understand that the information released may include treatment for physical and mental illness, alcohol, or drug use, AIDS or HIV testing.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand the need for medical care and consent to the services  **(PATIENT NAME)** provided by the Gallia County Reproductive Health & Wellness Clinic/Primary Care Clinic. These services include: social and educational services, laboratory procedures, medical treatment, examinations, diagnostic procedures and other services deemed necessary by the clinician. I have been told and understand that the services provided are for medical care only and do not include emergency services.

I give permission to **OBTAIN and/or RELEASE** my medical records to a Provider or organization concerned with providing further care or services to me. I release the staff of the Reproductive Health & Wellness Program/Primary Care Clinic from any liability resulting from disclosure of information in those medical records.

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If patient is a minor under 18:**

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_**

**For Under 18 Minors WITHOUT Parental Consent Only**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor, have been told by the staff of the Gallia County Reproductive Health & Wellness Clinic the following: 1) the legal implications of not having the consent of a parent/guardian for care and services provided in this clinic. 2) that it is advisable to have written permission from a parent/guardian for the care and treatment provided in this clinic.

 I do not, at this time, wish to inform my parent/guardian of my medical condition/pregnancy or of my involvement with the Reproductive Health & Wellness Program. The clinic staff has requested that I obtain the above-mentioned permission and I refuse to do so. This decision has been my own and I take full responsibility for my actions.

**Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GALLIA COUNTY HEALTH DEPARTMENT**

**PRIMARY CARE / REPRODUCTIVE HEALTH & WELLNESS CLINIC**

**Assignment of Insurance Benefits/ Financial Responsibility**

I authorize payment of my insurance benefits directly to the Gallia County Health Department. I understand that I am financially responsible for charges not covered by this authorization, and all bills not paid in a timely manner by my insurance carrier. I hereby consent to receiving auto-dialed and/or artificial or pre-recorded message calls, and/or text messages to my mobile device and to any telephone number provided by me with this encounter from the Gallia County Health Department. I understand this consent includes without limitation, any account management companies and independent contractors, including without limitation, any debt collectors.

All cash pay visits for Primary Care are due at the time of service. If your appointment involves getting lab drawn, 50% of the lab cost are due at the time of the visit. If you are unable to pay the amount in full you will have 12 months to pay the amount in full. If the amount is not paid in full no appointments or labs will be performed until the previous amount is paid.

Any Reproductive visits will be applied to our sliding fee scale, based on your income and household size). There is a financial hardship program for Reproductive needs if needed, ask to discuss with a staff member.

For any Out-of-Network insurance e.g. (Ohio Medicare or VA) we will offer the cash pay option of a base fee of $45 Office Visit. If labs are drawn LabCorp will bill your insurance for the cost of labs.

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature or Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**