WOMEN'S HEALTH & FAMILY SERVICES
Registration & Consent

Last Name: _____ First Name: _____ Middle Initial: ___ Maiden Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number to contact you to leave messages or test results (____) _____ Cell Number_____

Date of Birth: ____/___/____ Female ◯ Male ◯ Trans ◯ Birth Sex: F ◯ M ◯ Marital Status: S ◯ M ◯ D ◯ W ◯

Sexual Orientation: Heterosexual ◯ Homosexual(gay) ◯ Bisexual ◯

Social Security #_____ Student? ☐ Primary Care Physician_____

Employer_____ Employed Full Time ◯ Part Time ◯ Unemployed ◯

Your **e-mail address** for online access to your health information _____

Emergency Contact Name: _____ Relationship:_____ Phone #: (____)_____

Are you fearful of the consequences from your parents or Spouse and wish to be CONFIDENTIAL ◯YES OR ◯NO
From whom: _____

Do you speak or understand English Yes◯ / No◯ Is interpreter required Yes◯ / No◯ Do you have an interpreter Yes◯/ No◯

Preferred Pharmacy_____ Pharmacy Location_____

Please select one:
Ethnicity: ☐Not Hispanic ☐Latino ☐Hispanic

Please select one or more:
Race: ☐White ☐Black ☐Asian ☐Native Hawaiian ☐American Indian ☐African American ☐Other ☐Pacific Islander

GENERAL CONSENT FOR CARE AND TREATMENT

I consent to receive services offered to me (or my child) by Women's Health & Family Services (WHFS). I understand that I am receiving the services voluntarily and without any coercion from any other individual. I understand that receipt of family planning services are not a prerequisite to receipt of any other services offered. I understand that my services are provided in a confidential manner and the information contained in my record is confidential and will not be released without my written consent except as allowed by Iowa law including; reporting sexually transmitted and/or reportable communicable diseases, reporting child/adult abuse per Iowa Law, and allowing Federal & State funding representatives (including the Family Planning Council of Iowa) to review my records to review charges, services, and verify that quality services were provided. I understand that this information will remain confidential.

I understand that I may decline or defer services at any time

X_____ Date: _____
Patient Signature

Insurance Information
Do you have health insurance? (Please Circle one) ◯Yes ◯ No ◯ Unknown
(If yes, please show receptionist your card & enter information below)

	Primary Insurance	***Secondary Insurance***
Name of Insurance Company	_____	_____
Name of Policy Holder/Insured	_____	_____

I have provided all of my current insurance. The above information is true to the best of my knowledge. I authorize the insurance company or any third party payer to pay any benefits due directly to Women's Health & Family Services (WHFS). I also authorize WHFS or the insurance company to release any information required to process my claims. I understand that WHFS has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to WHFS, I agree to forward to WHFS all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. I understand that I am financially responsible for the payment of all services received and ordered even though insurance may be pending on all or a portion of the charges.
If a payment plan has been set up for me, I agree to comply with all payment terms with Women's Health & Family Services to avoid potential collection activity.

X_____ _____
Patient Signature **Date**