Planned Parenthood
Care. No matter what.
Planned Parenthood Southeastern Pennsylvania

215-351-5500
www.ppsp.org

REQUEST AND CONSENT FOR MEDICAL SERVICES
Form #/Revision date: a0001/1019

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 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 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 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 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 Southeastern Pennsylvania 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).

Financial Responsibility Policy
Form #/Revision date: a0812/0515

Thank you for choosing Planned Parenthood Southeastern Pennsylvania (PPSP) as your health care provider. Our Center is committed to providing the best health care for our patients at the lowest possible cost. Please understand that we require you to read and sign this statement of our Financial Policy, to make sure that you are aware of what is expected of anyone regarding payment for services.

Use of Insurance

PPSP accepts most insurance plans. It is your responsibility to know your benefits coverage prior to submitting insurance as payment for services at PPSP.
I understand and agree to the following:

- I authorize direct payment on my behalf from my insurance carrier(s) to PPSP.
- I am financially responsible for any services that I receive that are not covered by my insurance plan(s).
- I may receive a bill from my insurance carrier, a laboratory, or from PPSP for uncovered services or for my insurance member responsibility.
- If my insurance coverage was discontinued or does not cover these services, I may receive a bill both from an independent laboratory and / or from PPSP.
- I authorize PPSP to submit my insurance information to an independent laboratory for any testing that I receive. I authorize the release of information to process claims and or for Quality Assurance purposes including any information that may be indicative of HIV status.
- Correspondence from my insurance company or from PPSP may be sent to my address that indicates services that were provided.
- If I object to any part of this agreement, I may decline to use my insurance as payment for services today and discuss alternative payment options with PPSP staff.

Lab Services Disclaimer for Insurance Billing

Planned Parenthood Southeastern PA (PPSP) uses an outside lab for all Commercial Insurance Labs performed at our Centers. It is your responsibility as a covered member to know your benefits coverage.
I understand and agree to the following:

- My insurance company may not cover certain procedures, such as STD screenings and that the lab may bill me directly for these services.
- My insurance plan may have an authorized lab that PPSP is not contracted with and that I may choose to ask for a prescription for my lab-work, and go directly to the lab assigned by my insurance company.
- If I receive a bill for a service performed at PPSP from an outside lab, I may follow the following procedures:
  - Call the number listed on my bill to determine the reason for non-payment.
  - Call the Center where my services were provided and discuss my options with the Center Manager.
    - If PPSP made an error in the diagnosis, PPSP will make the correction and have the lab re-bill the claim to my insurance company.
    - If the service is not covered by my plan or the lab is not contracted with my insurance company, I will be charged on the PPSP sliding fee scale. Once I have paid PPSP for the service, PPSP will contact the lab directly and make sure the balance is removed.

Availability of Subsidized Services (Family Planning Patients Only)

The fees patients pay at Planned Parenthood are vital to allowing us to continue to provide services and it is your responsibility to pay for the services provided to you. However, you may be eligible to have all or part of your services subsided through a variety of state, federal and private programs. The financial information you provide about your household size and income will allow us to establish your eligibility for these subsidized services.

I understand and agree to the following:

- The financial information I have provided here is true and complete, to the best of my knowledge.
- I will provide documentation of any information I've reported here, if required.
- My fee discount may change if my circumstances or the fee scale changes.
- If I do not agree with the determination I may request to have my eligibility reviewed.
- If I choose not to answer the questions about my household size and income, PPSP will not be able to discount my services and I will be responsible for the full, non-discounted price.
- Payment is due at time of service, and PPSP will attempt to collect any unpaid balances.

Permission Form For Use of Email, Text and Recorded Voice Messages
Form #/Revision date: a0007/1018

I permit Planned Parenthood Southeastern Pennsylvania to send me e-mails, texts or recorded voice messages in the following manner and for the following, limited purposes:

- Tell me that my privacy has been breached (via email only)
- Send me appointment reminders
- Tell me to go to its website for forms or information before an appointment
- Send me a request to participate in customer surveys pertaining to the quality of my experience as a patient
- Ask me to phone the health center
- Inform me of a change in hours or services
- Send me forms to request medical records (via email only)

I understand that texts and recorded voice messages to my cell phone may be automatically dialed.

You should not sign this permission form if people who you don't want to view your medical information have access to your e-mail account or can view your text messages or hear your voice mail messages.

I acknowledge and accept that the agreed upon e-mails, text messages or voice messages sent to and from Planned Parenthood Southeastern Pennsylvania, may be read by everyone who gets or has access to them. They will know that the messages are from Planned Parenthood Southeastern Pennsylvania, and they will be able to view their content. I acknowledge and accept that anyone who can hear recorded voice messages left for me will also have access to this content.

CONDITIONS

1. I have read and agree to the above.

2. I may cancel this permission form at any time by notifying Planned Parenthood Southeastern Pennsylvania in writing. It will be effective on the date Planned Parenthood Southeastern Pennsylvania is notified of my cancellation, but it may take up to 30 days for no further e-mails, texts, or recorded voice messages will be sent to me by Planned Parenthood Southeastern Pennsylvania after the date this permission form is cancelled.

3. My healthcare and payment for my healthcare will not be affected if I do not sign this permission form.

4. I agree to release and hold harmless Planned Parenthood Southeastern Pennsylvania from any liability that may result from using the methods of communication I have given consent to in this permission form. This includes, but is not limited to, breaches of confidentiality or privacy that may come from using those methods of communication (except as required by law).

<u>PLEASE NOTE</u>: Please do not send any e-mails to Planned Parenthood Southeastern Pennsylvania, even in response to those e-mails Planned Parenthood Southeastern Pennsylvania has sent to you. Instead, Planned Parenthood Southeastern Pennsylvania encourages you to communicate with its health centers by phone or in person.

☐ Check here, if you **do not** want to receive electronic communications at this time. You may be asked at a future date to review and consider this consent.

By signing below, I am providing written informed consent regarding the preceding documents in which risks, benefits and alternatives for the services and procedures are explained in detail.

- Request and Consent for Medical Services Form
- Permission Form for Use of E-mail, Text and Recorded voice messages
- Financial Responsibility Policy Form

I understand that I am signing the Request and Consent for Medical Services, Financial Responsibility Policy, and the Electronic Communication consent form.

Signature of patient _____ Date _____

I witness the fact that the patient received the above mentioned information and said she/he read and understood same and had the opportunity to ask questions.

Signature of witness _____ Date _____

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that you have received Planned Parenthood Southeastern Pennsylvania's Notice of Privacy Practices (the "Notice"). The Notice describes in detail how we might use or disclose your protected health information. The Notice also discusses your rights and our duties with respect to your protected health information.

Signature of Patient (and person authorized to sign for patient when required) Date

Relationship to Patient: □ self □ parent □ legal guardian □ other _____

I witness that the patient received this information, said it was read and understood, and there was an opportunity to ask questions.

Signature of Witness Date

PLANNED PARENTHOOD SOUTHEASTERN PENNSYLVANIA USE ONLY

I attempted to obtain the patient's signature in acknowledgment of receipt of the Notice, but was unable to do so, as documented below:

Date:	Initials:	Reason:

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NON-DISCRIMINATION NOTICE

Planned Parenthood Southeastern Pennsylvania complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Planned Parenthood of Southeastern Pennsylvania does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

- Planned Parenthood Southeastern Pennsylvania provides free aids and services to people with disabilities to communicate effectively with us such as qualified sign language interpreters and written information in other formats (larger print, audio, accessible electronic formats, or other formats).

- Planned Parenthood Southeastern Pennsylvania provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, then please contact:

HIPAA Privacy Officer
1144 Locust Street
Philadelphia, PA 19107
HIPAA.PrivacyOfficer@ppsp.org
Phone: 215-351-5574
Fax: 215-351-5595

If you believe that Planned Parenthood Southeastern Pennsylvania has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, then you can file a grievance with: HIPAA Privacy Officer, 1144 Locust Street, Philadelphia, PA 19107, HIPAA.PrivacyOfficer@ppsp.org, Phone 215-351-5574 and Fax 215-351-5595. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, then PPSP's HIPAA Privacy Officer is available to help you. You also can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building, Washington, DC 20201
1- 800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/ file/index.html.

ATTENTION: Language assistance services, free of charge, are available to you. Please contact:

HIPAA Privacy Officer
HIPAA.PrivacyOfficer@ppsp.org
215-315-5574