Patient ID: _____ Date: _____

General Consents

Please review the following information. If you have questions, we are happy to talk with you about them. You may ask for a copy of this form.

Request for Medical Services & Notice of Privacy Practices

Medical Services: I have been/will be given information about any test(s), treatment(s), procedures(s), contraceptive method(s), to be provided, including the benefits, risks, possible problems/complications, and alternative options. I am free to ask questions about anything I do not understand. A healthcare provider 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 understand that at any time, I can change my mind about receiving medical services at Hope Clinic. I hereby request that a person authorized by Hope Clinic provide appropriate evaluation, testing, and treatment.

Notice of Privacy Practices: I understand that confidentiality will be maintained as described in Hope Clinic's *Notice of Privacy Practices.* I have been given an opportunity to review this notice and may receive a written or electronic copy by request. An electronic copy is publicly available on hopeclinic.com under "Appointment Instructions". I consent to the use and disclosure of my health information as described in the *Notice of Privacy Practices.*

Referrals: I will be given referrals for further diagnosis or treatment if necessary. I understand that if a referral is needed, I will assume responsibility for obtaining and paying for this care. I have been/will be told how to get care in case of an emergency.

Interpreter Services: I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my healthcare visit. I understand that free interpretive services are usually available by phone.

Hope Clinic is a teaching institution. This means that Hope Clinic trains medical providers, social workers, and other professionals. We do this in an effort to expand access to and competency in the provision of abortion care. Hope Clinic's providers are experts in abortion care and actively train other providers, including resident doctors and providers affiliated with other institutions. If a provider under training is on your care team, they will be working under direct supervision of a qualified provider and be preforming portions of medical care appropriate to their training level.

Reporting: I understand that certain information or test results may be reported to state agencies (health or social services) if required by law. This includes disclosures of child abuse/neglect, elder abuse/neglect, and intent to harm oneself or another person.

Financial Policy

Fees are calculated by services provided. I understand that my total fee may differ from the initial estimated fee secondary to information obtained during my appointment, the actual services rendered and/or additional services being requested.

Full payment is expected at the time of service. Hope Clinic wants to provide high quality medical care at an affordable price. In order to offer affordable services, we depend upon the patients we serve to make prompt payment for their services and supplies.

Methods of Payment: We accept cash and credit card as payment. Outside funding sources may be applied as a deduction to the total payment due. In some cases, written information about this funding or other documents will be required to apply these deductions.

We reserve the right to refuse to accept credit cards when the patient is not named on the card as an authorized user. We reserve the right to verify ownership of the card. Hope Clinic follows all laws pertaining to HIPAA. However, confidentiality cannot be guaranteed when payment is made by credit card. We reserve the right to disclose confidential information to obtain payment when credit card charges are disputed by the credit card holder or the credit card company.

Patient ID: _____ Date: _____

Electronic Communications

I permit Hope Clinic to send emails or text messages in the following manner and for the following, but not limited to, purposes:

- Send me appointment reminders
- Tell me to go to its website for forms or information
- Send me a request to participate in patient surveys pertaining to the quality of my experience as a patient
- Ask me to phone the office
- Inform me of a change in hours or services

Sensitive information, including lab results, referrals or diagnoses will not be sent via text or email (unless secure). Standard text messaging rates may apply.

I acknowledge and accept that the agreed upon emails and text messages from Hope Clinic may be read by everyone who gets or has access to them. They will know that the messages are from Hope Clinic, and they will be able to view their content.

If I have scheduled online and already entered my phone number and email address into the online scheduling system used by Hope Clinic, I understand it is my responsibility to request this information be updated or removed if I no longer wish to receive communications relevant to my appointment(s) at Hope Clinic.

My healthcare and payment for my healthcare will not be affected if I do not agree to permitted use of email and text messages. I agree to release and hold harmless Hope Clinic 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).

The email and phone number that I provided on the Patient Demographics Form completed today or that I entered into the online scheduling system will be used for electronic communications.

If I do NOT agree to the scope of permitted use of email and text messages, it is my responsibility to notify Hope Clinic staff verbally at the time I submit my paperwork, or in writing. I may cancel this permission form at any time by notifying Hope Clinic in writing. It will be effective on the date Hope Clinic is notified of my cancellation. No further emails or text messages will be sent to me by Hope Clinic after the date this permission is cancelled.

By signing this document, I attest I have reviewed and understand the information included in Hope Clinic's **Request for Medical Services & Notice of Privacy Practices, Financial Policy, and Electronic Communication**s.

_____ _____

Signature of Patient Date

_____ _____

Signature of Hope Clinic Staff Date