

NEICAC HEALTH SERVICES  
FAMILY PLANNING  
PROGRAM INTAKE FORM

CHART  
LABEL

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

Name: \_\_\_\_\_  
Last Name First Name MI

Maiden Name: \_\_\_\_\_

Previous Last Name(s): \_\_\_\_\_

SS #: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Sex: Fe M

**Address Information:**

**Office Use Only:** County Code: \_\_\_\_\_

Street Address/P.O. Box Apt. # City State Zip

**Contact Information:**

Can we send you information at the above address?  Yes  No Plain envelope?  Yes  No

If no, what address can we send it to?: \_\_\_\_\_

If you are under 18 are your parents aware that you are seeking services here? Yes No

Can we contact you by phone?  Yes  No Home Phone Number: \_\_\_\_\_

Can we leave a message/text?  Yes  No Cell Phone Number: \_\_\_\_\_

Cell Phone Company: \_\_\_\_\_ (needed for text messages)

Can we contact you by email?  Yes  No Email Address: \_\_\_\_\_

Alternate Contact Person (a person we could call or mail if we were unable to reach you):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

**Other Information:**

Race (circle all that apply) White Black Asian Pac. Islander Native Amer./Alaskan Eastern Indian

Are you Hispanic/Latino  Yes  No

Are you: Single Married Divorced Separated Widow

Do you live: Alone With Spouse/Partner With Children With Parents With Other

Household size: \_\_\_\_\_ (May Include Self, or Self & Spouse, & Family members ≤ 18 years of age)

Employer: \_\_\_\_\_ Full-time Part-time

School: \_\_\_\_\_ Full-time Part-time

Highest Grade Completed: \_\_\_\_\_

Do you currently have any insurance coverage for health care? ( Private, Medicaid, IFPN, Medicare)  Yes  No

Do you want us to bill your insurance for the services you receive today?  Yes  No

How are you related to the person with the insurance? \_\_\_\_\_

**Office Use Only:**

Copy of Insurance Card made today? Yes No If no, reason: \_\_\_\_\_

## VOLUNTARY AND CONFIDENTIAL CONSENT FOR SERVICES AND PAYMENTS

- I have been informed, understand, and consent to voluntarily receive services offered by NEICAC Health Services Family Planning.
- I understand these services are provided under the Iowa Department of Public Health.
- I hereby give NEICAC Health Services Family Planning permission to perform routine examinations and lab tests that may include urine test, blood test, PAP smear, STD screen, blood pressure, breast exam, and pelvic exam for family planning care/contraceptive care.
- I understand that NEICAC Health Services Family Planning has access to records maintained by NEICAC. I understand the Iowa Department of Public Health or any fiscal agents associated with the services provided by NEICAC Health Services Family Planning program has access to information contained in my record. My signature authorizes the release of my record by NEICAC Health Services Family Planning to these fiscal agencies when necessary.
- I understand that abstinence is the only method that is 100% effective to prevent pregnancy. I have received information on the use, effectiveness, known risks and side effects of available methods of contraception. This information may have been provided in pamphlets, fact sheets or video. I understand that the method I choose is not 100% effective. I release NEICAC Health Services Family Planning from any responsibility for method failure. I understand that I should contact this office regarding any questions, concerns, or side effects (symptoms) I may have about my birth control method/family planning services.
- I understand that if I have an abnormal PAP result, I will receive a letter indicating recommended follow-up.
- I understand that a positive STD result will be reported to the Iowa Department of Public Health.
- I understand that I will receive one complete exam, including lab tests and birth control for one year. If any follow-up or additional testing is needed, I must cover those costs. I release NEICAC Health Services Family Planning from any responsibility related to the care I choose to receive from my own physician for follow-up.
- I understand that all information I have provided is confidential and that my parent/guardian (if a minor) will be notified only in an emergency or if a life threatening condition exists.
  
- I understand that I am financially responsible to pay NEICAC Health Services Family Planning for all services received, including balances not covered by my insurance carrier(s). I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to NEICAC Health Services Family Planning, and direct the payment of proceeds be made directly to NEICAC Health Services Family Planning Program.
- I understand I am responsible for informing NEICAC Health Services Family Planning of all insurance coverage that I am eligible for.
- I authorize the release of medical record information or excerpts thereof to any insurance company or third party payor for utilization management audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization.
- I understand that any **discount applies to family planning services and birth control method related services ONLY**. I understand that my insurance carrier may pay according to what they deem as “usual and customary” and that NEICAC Health Services Family Planning Program does not have to accept this as payment in full. I agree to pay any charges not covered by insurance, Title XIX, or the family planning fee scale.

Iowa State Social Services regulations mandate that all Medicaid benefits be withheld until other insurance is investigated. Clients are legally responsible for providing information regarding possible coverage by another company. Compliance with these rulings will prevent the possibility of subsequent litigation.

**I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.** This consent will remain in effect for 1 year from signature date unless revoked by me in writing, and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this consent is to be considered as valid as the original.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Witness

\_\_\_\_\_  
Date

NEICAC Health Services

Family Planning Program

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