CLIENT REGISTRATION

First name _____ Pronouns _____

Legal name (first, middle, last) _____

Date of birth _____

Phone number _____

Address _____

If desired, provide a number for confidential voicemails _____

Last 5 digits of SSN (opt) _____

IN CASE OF EMERGENCY Contact _____
Phone _____
Email _____
Relationship _____

AGREEMENT TO PAY I agree to pay all the charges related to all services received here, including clinic visits & labs, & applicable copayments, coinsurance, & deductibles.

NOTICE OF PRIVACY PRACTICES I have been given this Notice. I am aware that I may request a copy at any time & this Notice may be revised at any time.

CONSENT FOR TREATMENT I, the undersigned, consent to & authorize any treatments, exams, medical services, or diagnostic, including labs.

_____ Date _____

Client's signature

Turn Over

MEDICAL HISTORY

Name _____

List all medicine allergies _____

List all food & drink allergies _____

List all chemical allergies _____

List all environmental allergies _____

List other sensitivities or reactions you have _____

Are you allergic to these medicines?

Penicillin	Yes ___	No ___
Ceftriaxone	Yes ___	No ___
Cephalosporins	Yes ___	No ___
Doxycycline	Yes ___	No ___
Tetracycline	Yes ___	No ___
Nitrofurantoin	Yes ___	No ___
Azithromycin	Yes ___	No ___
Clindamycin	Yes ___	No ___
Metronidazole	Yes ___	No ___

List past & current health issues _____

List current medications & supplements _____

Check what screening you want ___ Chlamydia & gonorrhea (urine combo test)
___ HIV & syphilis (fingertip blood combo test)

Signature _____ Date _____

Preventive Health Center of Iowa City, PLLC
221 College St, Suite 211, Iowa City, IA 52240
phcic52240@gmail.com 319-337-3313, x3

COMMUNICATIONS AGREEMENT

Name _____

Limited Availability Notice I understand that the Preventive Health Center of Iowa City, PLLC (PHCIC) is a small clinic without after-hour or 24-hour availability. I agree to keep my primary care provider updated on my care received here & to contact them with any medical concerns when the PHCIC is not open or not available for communications.

Email & Phone Notice Email is not a secure or urgent way to communicate; email confidentiality is not guaranteed. Privacy is best ensured by talking in person or via phone. Phone & email messages will be attempted to be returned within 48 business hours. If I choose to communicate via email, I will indicate this at the end of this page.

Text-Free Clinic Texting is not a secure form of communication & is not used at the PHCIC. The PHCIC's phone line does not accept texts. I agree to not text the PHCIC.

Fax Service Secure faxes can be sent to 319-337-0686 fax line. If I send a fax, I must notify the PHCIC by phone at 319-337-3313 x3 or via email at phcic52240@gmail.com to make the PHCIC aware a fax was sent. I understand that the fax will be read within 48 business hours after the notification of sending is received by the PHCIC.

For Urgent or Emergency Needs
For urgent or emergency care, I agree to get help by calling/texting 911 or going to the emergency department. For urgent mental health needs I agree to call/text 911 or 988 (Suicide Crisis Lifeline).

Communications Agreement Summary
I understand all the above. If I check the "I agree to use email" box, below, I give PHCIC permission to email communicate with me, which can be cancelled any time.

☐ I agree to use email Signature _____ Date _____

CONSENT TO RELEASE &/OR ACCESS INFORMATION

Legal name (first, middle, last) _____
First name _____ Pronouns _____ Previous names _____
Date of birth _____ Phone _____ Last 5 digits of SSN (opt) _____
My address _____

INFORMATION TO BE RELEASED &/OR RECEIVED WITHIN PAST YEAR (UNLESS SPECIFIED)

Summary of records ____ Lab reports ____ Medical visit notes ____
Counseling, psychotherapy, or mental health notes (see ☮) _____

I AUTHORIZE PREVENTIVE HEALTH CENTER OF IOWA CITY, PLLC, TO SEND INFORMATION TO HERE
Name or organization _____
Location or address _____
Reason for release of information (check): Medical___ Insurance___ Legal___Other___
Send information via these formats (check): Fax___ Electronic___ Paper___ Verbal___

☮ *The following information is releasable unless I specifically check one of these below* ☮

Substance use___ Mental health___ HIV-related information___ Genetics info___

I AUTHORIZE PREVENTIVE HEALTH CENTER OF IOWA CITY, PLLC, TO RECEIVE INFORMATION FROM HERE
Name or organization _____
Complete mailing address _____
Their location or address _____
Reason for release of information (check): Medical___ Insurance___ Legal___Other___
Receive information via these formats (check): Fax___ Electronic___ Paper___ Verbal___

Consent signature I understand that this request is good for 1 year & that I can request a copy, that recipients could re-release my information without my knowledge or proper authorization, & that if I cancel this request, my information may have already been released.

Signature _____ Date _____

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phcic52240@gmail.com 319-337-3313, x3

CONSENT FOR HIV SCREEN FOR MINORS

Your HIV Screen

A person under 18 years old in Iowa has legal capacity to consent to & act on provision of medical care or services for the prevention, diagnosis, or treatment of a sexually transmitted disease or infection. This is according to Iowa Code §139A.35.

If your HIV test is positive, the Iowa Department of Public Health:

a. Must receive the clinic's test result & my name & contact information.
b. Will attempt to determine the source of how you were exposed to HIV.
c. Must notify your parent(s) or guardian(s).
d. Will keep your test results confidential & inaccessible to the public.
e. May notify your local public health agency.
f. The information above (a. to e.) is per Iowa Code §139A.30.

Iowa Code §139A.35 "A minor shall have the legal capacity to act and give consent to provision of medical care or services to the minor for the prevention, diagnosis, or treatment of a sexually transmitted disease or infection by a hospital, clinic, or health care provider. Such medical care or services shall be provided by or under the supervision of a physician licensed to practice medicine and surgery or osteopathic medicine and surgery, a physician assistant, or an advanced registered nurse practitioner. Consent shall not be subject to later disaffirmance by reason of such minority. The consent of another person, including but not limited to the consent of a spouse, parent, custodian, or guardian, shall not be necessary."

Iowa Code Section §139A.30 "Reports to the department which include the identity of persons infected with a sexually transmitted disease or infection, and all such related information, records, and reports concerning the person, shall be confidential and shall not be accessible to the public. However, such reports, information, and records shall be confidential only to the extent necessary to prevent identification of persons named in such reports, information, and records; the other parts of such reports, information, and records shall be public records. The preceding sentence shall prevail over any inconsistent provision of this subchapter."

Turn Over

Discussion & Questions

Today you will be given information & be able to ask questions about:

a. The purpose of the test, Iowa law, & possible & unknown risks associated with it.
b. The meaning of either a positive (reactive) or negative (nonreactive) result.
c. How the test result is given only during a face-to-face visit.
d. Possible additional blood tests, resources & anything else (eg, prevention).

By Signing Below, I Confirm the Following

a. I request the HIV screen & consent to collection of a fingertip blood sample.
b. I have had time to ask questions & understand I will receive the results in person.
c. I understand the purpose & possible risks of the HIV screen; the meaning of a positive (reactive) or negative (nonreactive) result; & possible other next steps such as prevention discussion, required reporting of positive (reactive) result to parent(s) or legal guardian(s), &/or additional testing & treatment.
d. I will provide accurate & honest parent/guardian contact information below.
e. I have reviewed all the above & understand it all.

_____ _____ _____ _____

Printed name Signature Date of birth Date

Address _____ Last 5 digits of SSN (opt) _____

Phone _____ Email _____

List 1 or 2 Parent/Legal Guardian(s) — Contacted Only for Positive (Reactive) Tests

Name _____ Name _____

Phone 1 _____ Phone 1 _____

Phone 2 _____ Phone 2 _____

Email _____ Email _____

Preventive Health Center of Iowa City, PLLC
221 College St, Suite 211, Iowa City, IA 52240
phcic52240@gmail.com 319-337-3313, x3

FAX

Preventive Health Center of Iowa City, PLLC
319-337-3313 x3, phcic52240@gmail.com
221 College St, Suite 211, Iowa City, IA 52240
Fax 319-337-0686 Fax

To _____

Fax Number _____

Number of Pages Including This Page _____

From _____

Note _____

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