CHOICES
EXPRESS TESTING

Current Information

First Name:	Last Name:		
Address:			
City:	State:	Zip Code:	County:
Date of Birth: Age: _____ _____/_____/_____	Social Security Number: _____-_____-_____		
Phone: ( )_____-_____	May we identify ourselves? Yes No *May we text you? Yes No		
*Email _____ *While your text/e-mails will remain confidential please note both have inherent privacy risks.			

Please be aware, if we file with Medicaid, a detailed statement may be sent to the address of the Medicaid recipient.

Do we have permission to file with Medicaid? ____Yes ____No

Medicaid Number: _____

Purpose of Visit?

_____

Office Use Only

Today's Date: ____/____/____ Time of Arrival ____:____

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Client Survey

Please complete the following questionnaire so that our staff may be better equipped to serve your needs. This is a confidential survey that will be used for Choices Express Testing's purposes only. ***Please answer all of the following questions to the best of your ability.***

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race:

☐ White ☐ Black ☐ Native Hawaiian/Pacific Islander ☐ American Indian ☐ Asian ☐ Other _____

Ethnicity:

☐ Hispanic ☐ Non-Hispanic ☐ Other _____

Total household income:

☐ I don't know ☐ $0-$10,000 ☐ $10,000-$20,000 ☐ Government Assistance Only
☐ $20,000-$40,000 ☐ Over $40,000 ☐ Unemployed

Medical Coverage:

☐ Private Insurance ☐ Medicaid ☐ Medicare ☐ No Coverage

Education: If a student, what school do you attend? _____

Highest Level of Education Completed:

☐ Less then High School ☐ GED ☐ High School ☐ Trade School ☐ 2-Year College
☐ 4-Year College ☐ Some Graduate School ☐ Graduate School

Religion:

☐ Atheist ☐ Buddhist ☐ Catholic ☐ Christian ☐ Hindu ☐ Jehovah's Witness ☐ Jewish ☐ Mormon
☐ Muslim ☐ None ☐ WICCA ☐ Other: _____

Is your spiritual belief an important consideration in your sexual health decisions? ☐ Yes ☐ No

Heard about Choices Express Testing: (Check all that apply)

☐ Friend ☐ Facebook ☐ Google ☐ Website ☐ Other internet site ☐ Hospital/Doctor
☐ School ☐ Planned Parenthood ☐ Repeat Client ☐ Health Department ☐ Other Community Referral
☐ MSSU Campus Fair ☐ MSSU Coupon Booklet ☐ MSSU Chart Newspaper
☐ MSSU Other:_____

Name_____ **Date** _____/_____/_____

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Sexual Behavior Inventory

Have you experienced any problems or do you have any concerns about your sexual health?

Y N unsure

Have you ever had a sexually transmitted infection (STI)? Y N unsure

If yes, what infection?_____

Have your sex partners been male, female or both? _____

Did any of your partners have previous sex partners? Y N unsure

Does your partner have sex with only you? Y N unsure

What do you typically do to prevent disease? _____

What do you typically do to prevent pregnancy? _____

Please mark a Yes or No to indicate your opinion to the following statements:

_____ 1. I regret entering into sexual relationships.
_____ 2. I think sex before marriage is okay if both partners agree.
_____ 3. I wish I had sex sooner/at a younger age.
_____ 4. I wanted to wait to have sex until I was married.

Name: _____ Date of birth: _____/_____/_____ Date:_____/_____/_____

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Limitations of Services

Choices Express Testing is staffed with licensed medical professional personnel. The volunteers assisting in many areas of service at this Medical Clinic receive training in Sexually Transmitted Infections education. Volunteers do not serve with academic degrees in counseling/education, nor are they licensed by the State of Missouri; therefore the counseling/education provided is not intended as a substitute for professional counseling/education.

I understand that Choices Express Testing's volunteers are acting as an agent of Choices Express Testing to help provide me with the Sexually Transmitted Infection education services that I am requesting. If I develop a relationship with a Choices Express Testing volunteer that goes beyond the scope of Choices Express Testing services, I understand that the volunteer is no longer acting as an agent of Choices Express Testing.

I understand that Choices Express Testing will hold in confidence all the information that I provide them except in the following instances; if I am suicidal, homicidal, under age and being abused, or abusing someone else. I understand the above information and willingly enter into a relationship of accepting help and assistance from Choices Express Testing.

The Choices Express Testing is a part of LifeChoices Health Network. As needed, medical information may be shared between the clinics.

Name (Please print): _____

Signature (Full name): _____

Date of Birth: _____/_____/_____

Date: _____/_____/_____

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Consent for Testing and Treatment

The Choices Express Testing Clinic offers free medical services pertaining to sexually transmitted infections (STIs), including HIV. **Choices Express Testing does not provide general medical care, prenatal services or emergency services.** If you are experiencing acute pelvic pain, abnormal bleeding, a fever, or any other life-threatening illness, you should go to an emergency room immediately.

The following tests are available at Choices Express Testing:
HIV, Syphilis, Gonorrhea, Chlamydia, Herpes, Trichomonas, HPV, Bacterial Vaginosis, Yeast, Hepatitis B and Hepatitis C testing for female clients. Female clients will also be offered a pelvic exam/pap test appointment. **HIV, Syphilis, Gonorrhea, Chlamydia, Herpes, Hepatitis B and Hepatitis C testing** is available for male clients.

Choices Express Testing does not charge for services, including medical visits. However, laboratory fees - charged by the outsourced lab - may apply for some testing. These laboratory fees are passed to you, the client, at our cost and are due at the time of testing. Please ask the healthcare provider for a list of free tests and those that may have a lab fee associated.

Missouri law requires that a confirmed positive result for some STIs must be reported to the Missouri Department of Health for follow-up and treatment.

Information on healthcare, as it pertains to STIs and related subjects, will be provided. Choices Express Testing does not prescribe birth control.

I have read and understand the above information and request STI testing, including HIV testing. I give consent for STI testing voluntarily and without coercion. I understand that the STI results will be available to Choices Express Testing personnel who are directly involved with my care and have a reasonable need to know information contained in my medical record.
I agree to return to Choices Express Testing for my result(s) at the scheduled appointment. I understand my test results will not typically be given over the phone. I understand that test results will only be given over the phone, if 1) I am unable to keep my scheduled results appointment at Choices Express Testing and 2) if deemed medically necessary by the healthcare professional. I also understand that test results will only be discussed via the phone number I provide on my Consent for Follow-up form and I will be required to provide my unique identifier (social security number) before results are discussed.

_____	_____/_____/_____	_____/_____/_____
Client signature	**Date of Birth**	**Date**

_____	_____/_____/____
Witness signature	**Date**

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Follow-Up and Release of Information

You have consented to medical care through Choices Express Testing. In the event we need to contact you regarding rescheduling or treatment, please provide the appropriate information below.

Choices Express Testing personnel may contact me through a phone call in which they _____can _____cannot identify themselves. (Write your initials by the preferred method.)

Phone Number _____

Email Address _____

Choices Express Testing personnel may contact me through mail with an unmarked envelope.

Name _____

Address _____

City, State, Zip _____

I, _____, authorize Choices Express Testing to waive their confidentiality policy and discuss information about my visit to Choices Express Testing with the individuals and/or agencies listed below.

1. _____
2. _____
3. _____

_____ _____/_____/_____ _____/_____/_____
Client signature **Date of Birth** **Date**

_____ _____/_____/_____
Witness Signature **Date**