



**Informed Consent for Contraceptive Implant
(IMPLANON/NEXPLANON)**

Please read carefully and understand before signing. Initial where indicated.

_____ I have read the information given to me about the contraceptive implant (“the implant”) and I have discussed my concerns and questions with my health care provider. I have also received instructions about how to properly use the implant as a method of birth control.

_____ I understand that HealthPOiNT cannot guarantee the contraceptive implant to be 100% effective, but scientific studies have shown the implant to be more than 99% effective in preventing pregnancy.

_____ I understand that the implant will NOT protect me from sexually transmitted infections (STI) such as HIV, Chlamydia, genital warts, gonorrhea, syphilis, etc.

_____ I understand that I should not use the implant if I am pregnant, think I may be pregnant, or have breast cancer.

_____ I understand that the most common side effect is irregular bleeding, especially in the first 6-12 months of use. I understand that for most women, periods become fewer and lighter and that after one year, 1 out of 3 women who use the implant will stop having periods completely. Some women may have longer, heavier periods, while others have increased spotting and light bleeding between periods.

_____ I understand that less common side effects of the implant include: change in sex drive, discoloring or scarring of the skin over the implant, headache, nausea, pain at the insertion site, sore breasts, weight gain, and rarely, an infection or pain in the arm.

_____ I understand that there may be serious problems associated with the use of the implant, and I agree to tell my health care provider immediately if I:

- have bleeding, pus or increasing redness or pain at the insertion site
- have a new lump in my breast
- have no period after having a period every month
- have yellowing of the skin or eyes
- have unusually heavy or prolonged vaginal bleeding
- have concerns about the location of the implant or if the implant comes out

_____ I have been told that certain other drugs, medications, or herbal remedies, which I might take, could interact with the implant. I agree to let other health care providers know that I use the implant for birth control and about any other medications or treatments I am taking.

_____ I understand that the implant is effective in preventing pregnancy for up to three years, and that I may request my healthcare provider remove the implant sooner if I wish.

_____ Other means of birth control have been explained to me as alternatives to the implant.

_____ In requesting the implant, I hereby release BVCAA, inc./HealthPOiNT Clinics, including the attending clinician, the staff, and the assistants, from any responsibility for any conditions that may result from my using the implant or from a resulting pregnancy.

_____ I wish to use the implant as a method of birth control and intend to return as instructed for follow-up, or sooner if problems develop.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____

Revised: 04/15/2013

Approved:07/28/2014