Exhibit A-6

SERVICES RENDERED FORM
Oregon Health Authority
Oregon Vasectomy Project

For use by Vasectomist to indicate which services were provided for a RH Clinic-referred client. Please complete separate form for EACH service – one for the sterilization counsel and one for the vasectomy procedure. Information from this form will be used to bill for vasectomy services.

Provider Name: _____ Provider Phone: _____

Client Name: _____ Client DOB: _____

Date of Vasectomy Counsel (if applicable): _____

Date of Vasectomy Procedure (if applicable): _____

Check the boxes of services if performed:

COUNSELING PROVIDED *Only required if Sterilization Counsel performed*	**MEDICAL SERVICES** *Only required when Vasectomy performed*
☐ 01 – Contraceptive Options ☐ 03 – Sterilization [Required]	☐ 02 – Blood Pressure ☐ 20 – Sterilization Procedure ☐ 42 – Male Genitalia Exam ☐ 36 – Other Lab or Exam

Payment Amount Received (i.e. client fee, private insurance, Medicaid): _____

PROVIDER, BY SUBMITTAL OF THIS SERVICES RENDERED FORM, HEREBY DECLARES THE STATED SERVICES WERE PERFORMED.

Signature: _____ Date: _____