



Planned Parenthood Hudson Peconic, Inc.
Serving Suffolk, Westchester, Rockland and Putnam Counties

REGISTRATION FORM

Date _____

New Patient: Welcome and please complete the form.

Were you a patient at a Westchester County Family Planning Clinic in the last 2 years? Yes No

Returning Patient: Welcome back, please fill in type of visit, your name and date of birth. If there are any changes in the information below please complete the form.

Type of visit: Please indicate the type of visit you are planning on having today.

- Annual exam Medical problem visit Emergency Contraception Pregnancy Test
 Surgical Abortion Medication Abortion Prenatal Colposcopy
 Supply Visit Only (for returning patients only) Other _____

Do you need an interpreter to communicate with us? Yes No If yes, what language? _____

Name: _____ Sex: Female Male

Date of Birth: _____ Social Security #: _____ - _____ - _____

Address: _____
Street Apt. #

City State Zip

Phone () _____ () _____ () _____ () _____
Home Work Cell Emergency Phone

We must be able to contact you by phone Cell Phone Only Don't Leave a Message Say Dr. Calling OK to say PP

We must be able to contact you by mail PP Envelope Plain Envelope Star Letter/Plain Envelope

Do you have e-mail? Yes No If yes, e-mail address _____

Do you have Insurance? Yes No

If yes, what? Medicare/Medicaid FPEP FPBP Medicaid Managed Care Private Insurance

If Medicaid managed care or private insurance, name of insurance plan: _____

1. Weekly income _____ Number of people salary supports _____
2. Race: White Black American Indian Alaskan Native Asian/Pacific Islander Other
3. Hispanic Origin/Descent? Yes No
4. Are you currently employed? Full-time Part-time Unemployed
5. Student Status? Full-time Part-time Highest grade of school completed _____
6. Type of Birth Control you are currently using? _____
 If none, why? Infertility Not Sexually Active Not needed Other Medical Reasons
 Pregnancy Relying on Partner's Method Seeking pregnancy
7. Have you ever been pregnant? Yes No # of pregnancies before visit _____ # of Births _____
 # of stillbirths _____ # of miscarriages _____ # of abortions _____
8. Were you pregnant in the last 2 years? Yes No
9. Did you have Medicaid when your last pregnancy ended? Yes No
10. In addition to Planned Parenthood do you also get healthcare services elsewhere? Yes No
 If Yes, where? _____

Patient's signature: _____

OFFICE USE ONLY

Proof of Income: Payroll Stub Letter of Attestation Copy of Check Other _____

Date: _____ Staff signature _____



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HOJA DE REGISTRO

Fecha _____

Si visita este Centro por primera vez. Bienvenido. Por favor complete la siguiente forma.

¿Era usted un paciente en la clínica de planificación familiar del condado de Westchester en los últimos 2 años?

Sí No

Si ha estado antes en este Centro. Bienvenido nuevamente. Por favor, complete la siguiente forma incluyendo cualquier información distinta de la que usted proveyó en su visita anterior.

Tipo de visita: Por favor, indíquenos qué servicio requiere usted hoy.

- Examen anual Problema médico Anticonceptivo de emergencia Prueba de embarazo
 Aborto quirúrgico Aborto médico Cuidado prenatal Colposcopia
 Visita para buscar provisiones (sólo para pacientes que han visitado el Centro anteriormente)
 Otro servicio o propósito _____

¿Necesita usted un traductor/a para comunicarse con nosotros? Sí No Si es así, ¿Qué idioma habla? _____

Nombre: _____ Género: Mujer Hombre

Fecha de nacimiento: _____ Número de Seguro Social: _____ - _____ - _____

Dirección: _____
Calle Apt. #

_____ Ciudad Estado Código Postal
 Teléfono () _____ () _____ () _____ () _____
Casa Trabajo Teléfono celular Teléfono de Emergencia

De necesitar comunicarnos con usted, por favor, indíquenos la mejor manera de hacerlo:

Por teléfono: Celular No dejar mensaje Decir que el doctor llamó Decir que Planned Parenthood llamó

Por correo: Con un sobre en blanco Con sobre de Planned Parenthood Con una estrella/y un sobre en blanco

¿Tiene e-mail? Sí No Dirección de e-mail _____

¿Qué seguro médico tiene?

Medicaid FPEP FBPB Medicaid Managed Care Seguro privado No tengo seguro

Si es Medicaid Managed Care o un seguro privado, por favor provea el nombre: _____

1. Ingreso _____ Semanal Número de personas que dependen de este ingreso _____
2. Raza: Blanco Negro Indio Americano Nativo de Alaska Asiático Otro
3. ¿Es usted Hispano/Latino? Sí No
4. ¿Trabaja actualmente? Tiempo Completo Medio tiempo Desempleado
5. ¿Está en la escuela ahora? Tiempo completo Medio tiempo
 Grado más alto de escuela que ha completado _____
6. ¿Tipo de control de natalidad que está usando actualmente? _____
 Si ninguno, ¿por qué? Infertilidad No tiene relaciones sexuales Otra razón médica
 Embarazada Confía en el método utilizado por su pareja
 Busca salir embarazada
7. ¿Ha estado embarazada? Sí No Número de embarazos antes de esta visita _____ Número de partos _____
 Número de nacidos muertos _____ Número de abortos naturales _____ Número de abortos _____
8. ¿Estuvo embarazada durante los últimos dos años? Sí No
9. ¿Tenía Medicaid al momento de terminar su último embarazo? Sí No
10. ¿Además de Planned Parenthood, utiliza usted otro centro de cuidado de salud? Sí No
 ¿Cuál? _____

Firma del paciente: _____

OFFICE USE ONLY

Proof of Income: Payroll Stub Letter of Attestation Copy of Check Other _____

Date: _____ Staff signature _____



Planned Parenthood Hudson Peconic, Inc.
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**REQUEST FOR THE PROVISION OF MEDICAL SERVICES AND
 ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY
 PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

DATE: _____

SOCIAL SECURITY #: _____

TELEPHONE #: _____

| | |
|--------------------|-----------|
| Patient Name _____ | |
| Patient # _____ | DOB _____ |

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I have been given information about the test(s), treatment(s), procedure(s) contraceptive method(s), to be provided, including the benefits, risks, possible problems/complications and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Planned Parenthood.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as much as possible, subject to Planned Parenthood Hudson Peconic, Inc.'s *Notice of Health Information Privacy Practices*. I hereby acknowledge receipt of Planned Parenthood Hudson Peconic, Inc.'s *Notice of Health Information Privacy Practices*, and I have had the right to review the *Notice* prior to signing this Request for the Provision of Medical Services.

I consent to the use and disclosure of my health information as described in Planned Parenthood Hudson Peconic, Inc.'s *Notice of Health Information Privacy Practices*. Except for the reasons described in the *Notice*, I may revoke this consent in writing at any time using the procedure in the *Notice*. I agree that this consent supercedes any and all previous consents, authorizations, releases, and other written legal permissions signed by me regarding use and disclosure of health information covered by this consent, and I release Planned Parenthood Hudson Peconic, Inc. and its health care providers from all liabilities related to their compliance with this consent.

| |
|-------------------------|
| Patient Name_____ |
| Patient #_____ DOB_____ |

This is to certify that I have read this Request for the Provision of Medical Services, understand its content, and accept its terms. I hereby request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

Signature of Patient _____ Date_____

I witness the fact that the patient received the above mentioned information and said she/he read and understood same and had the opportunity to ask questions.

Signature of Witness_____ Date_____

| |
|---|
| CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW |
| Signature of any other person consenting _____ |
| Relationship to patient _____ |
| Date _____ |
| I witness the fact that the patient's legal guardian (or person consenting in her behalf) received the above mentioned information and said she read and understood same. |
| Signature of Witness _____ |
| Date _____ |

HIV is the virus that causes AIDS.

- HIV is passed from one person to another during unprotected sex (vaginal, anal or oral sex without a condom) with someone who has HIV.
- HIV is passed through contact with blood as in sharing needles (piercing, tattooing or injecting drugs of any kind) or sharing works with a person who has HIV.

The only way to know if you have HIV is to be tested.

- HIV tests are safe. They involve collecting one or more specimens (blood, oral fluid, urine).
- Your counselor or doctor will explain your test result as well as any other tests you may need.

Your HIV test today includes:

- A test to see if you have HIV infection (an antibody test or a test for the virus);
- If you are HIV positive, additional tests may include tests to:
 - help your doctor decide the best treatment for you.
 - help guide the health department with HIV prevention programs.

Several testing options are available.

- You can choose to have a confidential test where the result becomes part of your medical record and can be given to your health care provider for HIV and other health care services, or
- You can choose to have an anonymous test, which means that you don't give your name and no record is kept of the test result. If your anonymous test is HIV-positive, you can choose to give your name later so you can get medical care more quickly.
- To get more information about options for testing and free or anonymous testing sites, ask your counselor/doctor or call 1-800-541-AIDS.

HIV testing is important for your health.

- If your test result is negative, you can learn how to protect yourself from being infected in the future.
- If your test result is positive:
 - You can take steps to prevent passing the virus to others.
 - You can receive treatment for HIV and learn about other ways to stay healthy. As part of treatment, additional tests will be done to determine the best treatment for you. These tests may include viral load and viral resistance tests.

HIV testing is especially important for pregnant women.

- An infected mother can pass HIV to her child during pregnancy or birth or through breastfeeding.
- It is much better to know your HIV status before or early in pregnancy so you can make important decisions about your own health and the health of your baby.
- If you are pregnant and have HIV, treatment is available for your own health and to prevent passing HIV to your baby. If you have HIV and do not get treatment, the chance of passing HIV to your baby is one in four. If you get treatment, your chance of passing HIV to your baby is much lower.
- If you are not tested during pregnancy, your provider will recommend testing when you are in labor. In all cases, your baby will be tested after birth. A positive test on your baby means that you have HIV and your baby has been exposed to the virus.

If you test positive:

State law protects the confidentiality of your test results and also protects you from discrimination based on your HIV status.

- In almost all cases, you will be asked to give written approval before your HIV test result can be shared.
- Your HIV information can be released to health providers caring for you or your exposed child; to health officials when required by law; to insurers to permit payment; to persons involved in foster care or adoption; to official correctional, probation and parole staff; to emergency or health care staff who are accidentally exposed to your blood; or by special court order.
- The names of persons with HIV are reported to the State Health Department for tracking the epidemic and for planning services.
- The HIV Confidentiality Hotline at 1-800-962-5065 can answer your questions and help with confidentiality problems.
- The New York State Division of Human Rights at 1-800-523-2437 can help if you think you've been discriminated against based on your HIV status.

Your counselor/doctor will talk with you about notifying your sex or needle-sharing partners of possible exposure to HIV.

- Your partners need to know that they may have been exposed to HIV so they can be tested and get treated if they have HIV.
- If your health care provider knows the name of your spouse or other partner, he or she must report the name to the health department.
- Health department counselors can help notify your partner(s) without ever telling them your name.
- To ensure your safety, your counselor or doctor will ask you questions about the risk of domestic violence for each partner to be notified.
- If there is any risk, the Health department will not notify partners right away and will assist you in getting help.

Important Phone Numbers

New York State HIV/AIDS Hotlines (toll-free)

Call the Hotlines for information about HIV and AIDS and to find HIV testing sites

- 1-800-541-AIDS (2437) • English
- 1-800-233-SIDA (7432) • Spanish

New York State TTY/TTD HIV/AIDS Information Line

- 1-212-925-9560

Voice callers use the NY relay:

- 711 or 1-800-421-1220 and ask the operator for: 1-212-925-9560

New York State HIV/AIDS Counseling Hotline

- 1-800-872-2777

NYSDOH Anonymous HIV Counseling and Testing Program

For HIV information, referrals, or information on how to get a free, anonymous HIV test, call the Anonymous HIV Counseling and Testing Programs.

- Albany Region 1-800-962-5065
- Buffalo Region 1-800-962-5064
- Nassau Region 1-800-462-6785
- New Rochelle Region 1-800-828-0064
- Queens Region 1-800-462-6785
- Rochester Region 1-800-962-5063
- Suffolk Region 1-800-462-6786
- Syracuse Region 1-800-562-9423

NYCDOHMH HIV/AIDS Hotline: 1-800-TALK-HIV (1-800-825-5448)

New York State PartNer Assistance Program: 1-800-541-AIDS

New York City Contact Notification Assistance Program: 1-212-693-1419

Confidentiality

- New York State Confidentiality Hotline 1-800-962-5065
- Legal Action Center 1-212-243-1313 or 1-800-223-4044

Human Rights/Discrimination

- New York State Division of Human Rights 1-800-523-2437
- New York City Commission on Human Rights 1-212-306-7500

Informed Consent to Perform HIV Testing

HIV testing is voluntary. Consent can be withdrawn at any time by informing your provider. Please read Parts A and B of this form, and sign at the bottom of Part B, if you understand the following information and want HIV testing.

HIV infection is a serious health concern. The New York State Department of Health recommends HIV testing. For pregnant women, the Department recommends HIV testing early in pregnancy and again late in pregnancy.

Except for expedited HIV testing on labor units, this form replaces other HIV testing consent forms as of June 1, 2005.

NOTE: this form is intended to be used in conjunction with DOH-2556, Part B.

Part

A

My health care provider has answered any questions I have regarding HIV testing and has given me written information with the following details about HIV testing:



- HIV is the virus that causes AIDS.
- The only way to know if you have HIV is to be tested.
- HIV testing is important for your health, especially for pregnant women.
- HIV testing is voluntary. Consent can be withdrawn at any time.
- Several testing options are available, including anonymous and confidential.
- State law protects the confidentiality of test results and also protects test subjects from discrimination based on HIV status.
- My health care provider will talk with me about notifying my sex or needle-sharing partners of possible exposure, if I test positive.

I agree to testing for the diagnosis of HIV infection. If I am found to have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time.

For pregnant women only:

In addition to the testing described above, I authorize my health care provider to repeat HIV diagnostic testing later in this pregnancy. I understand that my health care provider will discuss this testing with me before the test is repeated and will provide me with the test results. The consent to repeat diagnostic testing is limited to the course of my current pregnancy and can be withdrawn at any time.

Signature: _____ Date: _____
(Test subject or legally authorized representative)

If legal representative, indicate relationship to subject: _____

Printed Name: _____

Medical Record #: _____

Except for expedited HIV testing on labor units, this form replaces other HIV testing consent forms as of June 1, 2005.

NOTE: this form is intended to be used in conjunction with DOH-2556i, Part A.