

STI TESTING WITHOUT EXAM

Planned Parenthood Hudson Peconic offers testing for sexually transmitted infections (STIs) without an exam. This service is offered to increase access to STI testing so that more people are tested and treated.

You can be tested without an exam for any of the following STIs. Not everyone needs to be or should be tested for all of these. We will discuss these tests with you before performing them.

- Urine for gonorrhea and chlamydia
- Blood drawn for Syphilis
- HIV Antibody
- Hepatitis B

STI testing without an exam is for people who do **not** have symptoms and do **not** think that their partner has an STI. You should talk with a clinician and possibly have an exam and get treatment if:

- Your partner has told you he/she has an STI
- You have any rashes, bumps or sores on your genitals
- You have discharge (fluid) from your vagina / penis
- You have pain when you urinate
- You have pain in your abdomen
- You think you may have an STI
- You are pregnant

Many sexually transmitted infections may be present without obvious symptoms. Therefore, there are limitations to the option of *STI testing without exam*. This may include, but is not limited to, the identification of small lesions suggesting a sexually transmitted infection. With the option of testing with an exam, the clinician may recommend additional sexually transmitted infection testing based on the clinical findings.

If you choose to have STI testing without an exam, you will meet with a counselor and/or clinician who will talk to you about the tests you are having, how to lower your risk for getting STIs, and how to get your test results. Please ask any questions you have about STIs and how to keep yourself healthy.

For most of these infections, if you test positive, New York State law requires us to report your name, address, and birth date and which infection you have to the state health department.

We strongly recommend that women have an exam once a year.

Exams are offered at the following centers:

<input type="checkbox"/> Amagansett	618 Montauk Highway	Amagansett 11930	phone: (631) 267-6818	fax: (631) 267-2510
<input type="checkbox"/> Brewster	2505 Carmel Avenue	Brewster 10509	phone: (845) 278-7313	fax: (845) 278-7221
<input type="checkbox"/> Huntington	755 New York Avenue	Huntington 11743	phone: (631) 427-7154	fax: (631) 427-1381
<input type="checkbox"/> Mount Kisco	280 North Bedford Road	Mount Kisco 10549	phone: (914) 666-6025	fax: (914) 666-7712
<input type="checkbox"/> Mount Vernon	14 South Second Avenue	Mount Vernon 10550	phone: (914) 668-7927	fax: (914) 668-7967
<input type="checkbox"/> New Rochelle	247-249 North Avenue	New Rochelle 10801	phone: (914) 632-4442	fax: (914) 632-4625
<input type="checkbox"/> Patchogue	450 Waverly Avenue	Patchogue 11772	phone: (631) 475-5705	fax: (631) 289-6484
<input type="checkbox"/> Riverhead	550 East Main St., Ste. 100	Riverhead 11901	phone: (631) 369-0230	fax: (631) 369-5582
<input type="checkbox"/> Smithtown	70 Maple Avenue	Smithtown 11787	phone: (631) 361-7526	fax: (631) 361-7678
<input type="checkbox"/> Spring Valley	25 Perlman Dr.	Spring Valley 10977	phone: (845) 426-7577	fax: (845) 426-6006
<input type="checkbox"/> West Islip	180 Sunrise Highway	West Islip 11795	phone: (631) 893-0150	fax: (631) 893-0146
<input type="checkbox"/> White Plains	175 Tarrytown Road	White Plains 10607	phone: (914) 761-6566	fax: (914) 948-5533
<input type="checkbox"/> Yonkers	20 South Broadway	Yonkers 10701	phone: (914) 965-1912	fax: (914) 965-8129



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 _____



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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 _____