

Male Medical History

PATIENT NAME _____ TODAY'S DATE _____

CHART NUMBER _____ CLINIC NAME _____

AGE _____ D.O.B. _____ ALLERGIES _____

PATIENT INFORMATION

(Please Print Clearly)

Address _____

STREET

CITY

STATE

ZIP

Home Phone _____ Work Phone _____ Pager/Cell Phone _____

Please check all the ways we may contact you:

Call Home Call Work Leave message Write Home (plain envelope) Other _____

Yes **No** Can we identify ourselves as **Planned Parenthood** if we call you? If **No**, code name _____

EMERGENCY CONTACT

Name _____ Relationship _____ Code Name **Yes** **No** _____

Address _____ Phone: (_____) _____

PAST MEDICAL HISTORY

List all current medical problems/conditions: _____

List all medications or drugs you are now taking or take often including over-the-counter medications, herbal medications and vitamins _____

Have you ever had surgery, a major illness, been a patient in a hospital, received a blood transfusion or exposure to blood products? **Yes** **No** If Yes, please explain _____

Immunization History – Have you received any of these immunizations?

Rubella (German Measles) **Yes** **No** Hep B Series **Yes** **No**

Others please specify (e.g. Polio, Mumps, Small Pox, Tetanus, etc.) _____

FAMILY HISTORY

If you are ADOPTED and do not know your biologic family's medical history, skip this section.

Indicate who of your blood relatives (Parents, Brothers, or Sisters ONLY) have or had any of the following problems. (WRITE N/A, IF NOT APPLICABLE)

Who	Who	Who	Who
_____ Heart attack / coronary artery disease	_____ High blood pressure	_____ Stroke	_____ Spina Bifida
_____ High cholesterol / High blood fats	_____ Phlebitis / clots in veins	_____ Diabetes	
_____ Sickle Cell/Tay Sachs/Thalassemia/PKU	Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	Type _____	

If other describe: _____

SOCIAL HISTORY

Occupation _____

Do you smoke? **Yes** **No** If so, how many cigarettes per day? _____

Do you drink alcohol? **Yes** **No** If so, how often/how much? _____

Do you use street, recreational or IV drugs? **Yes** **No** If so, what? _____ Past use? **Yes** **No**

STI HISTORY

Check if you have had one of the following Sexually Transmitted Infections (STIs):

- Herpes** **Gonorrhea** **Syphilis** **Hepatitis B/Hepatitis C**
- Chlamydia** **Venereal Warts/HPV** **Molluscum** **Partner with urethritis or other STI**
- Trichomonas** **Scabies/Lice/Crabs** **Other, describe:** _____

CONTRACEPTIVE HISTORY

- Yes** **No** Are you currently using a method of birth control? If **Yes**, which method _____
- Yes** **No** **Not Sure** Is your partner using a method of birth control? If **Yes**, which method _____
- Yes** **No** Do you want more information about birth control?

SEXUAL HISTORY

These questions may seem personal but they help us to evaluate your health. All information is confidential.

Have you had sexual intercourse? **Yes** **No** Age at first intercourse _____

Are you currently in a sexual relationship? **Yes** **No**

Is your sexual contact (→ all that apply): Vaginal Anal Oral Other _____

Have you had more than 1 partner in the past year? **Yes** **No** How many? _____

Are your partner(s) Male Female Both

Do you use condoms? **Yes** **No** Next to abstinence, safe sex, (condoms) are your best defense against sexually transmitted infections.

Do you want testing for STIs? **Yes** **No** Do you want testing for HIV? **Yes** **No**

Do you want to discuss problems related to rape, sexual or physical abuse today? **Yes** **No**

REVIEW OF SYSTEMS

Do you have any of the following (please check each item):

1. GENERAL

- Yes** **No** My health is generally good
- Yes** **No** Drug or alcohol problem
- Yes** **No** Recent weight gain or loss of 25 lbs
- Yes** **No** Cancer: Past/Present Type _____

2. CARDIOVASCULAR

- Yes** **No** Shortness of breath (other than with exercise or smoking)
- Yes** **No** Blood clots
- Yes** **No** Heart disease
- Yes** **No** Heart murmur
- Yes** **No** Do you take medication prior to dental work
- Yes** **No** Stroke
- Yes** **No** **High Blood Pressure**

3. EYES

- Yes** **No** Eye problems/visual problems (not related to needing or wearing glasses)

4. NEUROLOGIC

- Yes** **No** Seizure/Epilepsy
- Yes** **No** Migraine headaches (diagnosed)
- Yes** **No** Visual changes
- Yes** **No** Other severe headaches

5. EARS, NOSE, THROAT, MOUTH

- Yes** **No** Hearing problem
- Yes** **No** Frequent nose bleeds (more than 1 per month)
- Yes** **No** Frequent sore throat (more than 1 per month)

6. RESPIRATORY

- Yes** **No** Asthma Treatment _____
- Yes** **No** Tuberculosis Treatment _____
- Yes** **No** Lung Disease

7. GASTROINTESTINAL

- Yes** **No** Nausea/vomiting
- Yes** **No** Abdominal pain
- Yes** **No** Stomach/bowel problems
- Yes** **No** Liver disease
- Yes** **No** Gallbladder disease

8. ALLERGY/IMMUNOLOGIC

- Yes** **No** Hayfever
- Yes** **No** Do you have any allergies to medications?
If yes, list _____
- Yes** **No** Do you have any allergies to foods?
- Yes** **No** History of Lupus or other Autoimmune disease?

9. SKIN/BREAST

- Yes** **No** Acne
- Yes** **No** Pain in your breasts
- Yes** **No** Discharge from your nipples
- Yes** **No** Mass/lump in your breast
- Yes** **No** Breast disease/tumor/surgery

10. GENITAL URINARY

- Yes No Bladder/kidney problems
- Yes No Urinary pain
- Yes No Urinary frequency
- Yes No Losing or leaking urine

11. PSYCHIATRIC

- Yes No Depression
- Yes No Anxiety
- Yes No Seeing a therapist or psychiatrist
- Yes No Suicide attempt When _____
Counseling Yes No
- Yes No Feeling suicidal now

12. ENDOCRINOLOGY

- Counseling Yes No
- Yes No Eating disorder When _____
- Yes No Diabetes
- Yes No Thyroid Problem

13. HEMATOLOGY

- Yes No Blood disorder/Hemophilia
- Yes No Anemia
- Yes No High cholesterol/Triglycerides

Last tested _____

Results _____

Treatment Yes No

Patient Signature _____

Today's Date _____

DO NOT WRITE BELOW THIS LINE

- Yes N/A All birth control methods pamphlet given
- Yes N/A Breast self exam brochure offered
- Yes N/A Consent form signed
- Yes N/A Reading FDA inserts encouraged
- Yes N/A Contact preference
- Yes N/A STI information offered
- Yes N/A Information about safer sex given
- Yes N/A HIV information offered
- Yes N/A Method specific fact sheet given and discussed
- Yes N/A if patient <18, Adolescent counseling per protocol
- Yes N/A Birth control method and back-up method explained
- Patient verbalizes how to safely stop the method of choice and how to use alternate birth control methods including barrier methods, which prevent HIV and other sexually transmitted infections.

STAFF SIGNATURE / TITLE _____ DATE _____

History Update/Today's Date _____

Dear Patient,

Please review the information you gave us last year at your visit. If any items have changed, please indicate the changes in the space below:

Your Signature _____

Today's Date _____

Staff Signature/Title _____

Date _____

History Update/Today's Date _____

Dear Patient,

Please review the information you gave us last year at your visit. If any items have changed, please indicate the changes in the space below:

Your Signature _____

Today's Date _____

Staff Signature/Title _____

Date _____

1057 Kingston Ave., Los Angeles, 90033
560 S. St. Louis St., Los Angeles, 90033
916 W. Burbank Blvd., M, Burbank, 91502
21001 #9 Sherman Way, Canoga Park, 91303
8520 So. Broadway, Los Angeles, 90003
4786 ½ N. Peck Rd., El Monte, 91732
1014 ½ N. Vermont, Los Angeles, 90029

(323) 226-0800
(323) 226-0800
(818) 843-2009
(818) 843-2009
(323) 226-0800
(626) 443-3844
(323) 226-0800

5525 E. Del Amo Blvd., Lakewood, 90713
1550 N. Garey Ave., Pomona, 91767
1316 3rd St. Promenade, #201, Santa Monica, 90401
14623 Hawthorne Blvd., Ste 300, Lawndale, 90260
7100 Van Nuys Blvd., Ste 108, Van Nuys, 91405
7655 Greenleaf Ave., Whittier, 90602

(562) 866-0556
(909) 620-4268
(310) 787-2666
(310) 787-2666
(818) 843-2009
(562) 866-0556

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED BY PLANNED PARENTHOOD LOS ANGELES AND HOW TO ACCESS THIS INFORMATION

Effective Date Of This Notice: April 14, 2003

PLEASE REVIEW THIS NOTICE CAREFULLY

If you have any questions about this notice, please contact PPLA's Privacy Official at 323.223.4462.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

We understand that health information about you and your healthcare is personal. We are committed to protecting health information about you. We will create a record of the care and services you receive from us. We do so to provide you with quality care and to comply with any legal or regulatory requirements.

This Notice applies to all of the records generated or received by PPLA, whether we documented the health information, or another doctor forwarded it to us. This Notice will tell you the ways in which we may use or disclose health information about you. This Notice also describes your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

Our pledge regarding your health information is backed-up by Federal law. The privacy and security provisions of the Health Insurance Portability and Accountability Act ("HIPAA") require us to:

- Make sure that health information that identifies you is kept private;
- Make available this notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we may use or disclose health information about you. Unless otherwise noted each of these uses and disclosures may be made without your permission. For each category of use or disclosure, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, unless we ask for a separate authorization, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use health information about you to provide you with healthcare treatment and services. We may disclose health information about you to doctors, nurses,

technicians, health students, volunteers or other personnel who are involved in taking care of you. They may work at our offices, at a hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy, or other healthcare provider to whom we may refer you for consultation, to take x-rays, to perform lab tests, to have prescriptions filled, or for other treatment purposes. For example, a doctor treating you may need to know if you have diabetes because diabetes may slow the healing process. We may provide that information to a physician treating you at another institution.

For Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, a state Medicaid agency or a third party. For example, we may need to give your health insurance plan information about your office visit so your health plan will pay us or reimburse you for the visit. Alternatively, we may need to give your health information to the state Medicaid agency so that we may be reimbursed for providing services to you. In some instances, we may need to tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Healthcare Operations: We may use and disclose health information about you for operations of our healthcare practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study healthcare delivery without learning who our specific patients are.

Research. There may be situations where we want to use and disclose health information about you for research purposes. For example, a research project may involve comparing the efficacy of one medication over another. For any research project that uses your health information, we will either obtain an authorization from you or ask an Institutional Review or Privacy Board to waive the requirement to obtain authorization from you.. A waiver of authorization will be based upon assurances from a review board that the researchers will adequately protect your health information.

As Required By Law. We will disclose health information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans. If you are a member of the armed forces or are separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose health information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;

- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to an order issued by a court or administrative tribunal. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only after efforts have been made to tell you about the request and you have time to obtain an order protecting the information requested.

Law Enforcement. We may release health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- If you are the victim of a crime and we are unable to obtain your consent;
- About a death we believe may be the result of criminal conduct;
- In an instance of criminal conduct at our facility; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Such releases of information will be made only after efforts have been made to tell you about the request and you have time to obtain an order protecting the information requested.

Coroners, Health Examiners and Funeral Directors. We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have certain rights to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records. This does not include psychotherapy notes.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing on a form provided by us to: "The Privacy Official at PPLA." If you request a copy of your health information, we may charge a fee for the costs of locating, copying, mailing or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may in certain instances request that the denial be reviewed. Another licensed healthcare professional chosen by our practice will review your
PPLA #HIPAA 001 (12/05)

request and the denial. The person conducting the review will not be the person who denied your initial request. We will comply with the outcome of the review.

Right to Amend. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing on a form provided by us and submitted to: "The Privacy Official at PPLA."

We may deny your request for an amendment if it is not the form provided by us and does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for our practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures. You have the right to request a list (accounting) of any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list of disclosures, you must submit your request on a form that we will provide to you. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003 [The compliance date of the Privacy Regulation]. The first list of disclosures you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date should not exceed a total of 60 days from the date you made the request.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. For example, you could ask that access to your health information be denied to a particular member of our workforce who is known to you personally.

While we will try to accommodate your request for restrictions, we are not required to do so if it is not feasible for us to ensure our compliance with law or we believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request on a form that we will provide you. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain manner or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box. During our intake process, we will ask you how you wish to receive communications about your health care or for any other instructions on notifying you about your health information. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to obtain a paper copy of this Notice at any time upon request. You may also obtain a copy of this Notice at our website.

MINORS AND PERSONS WITH GUARDIANS

Minors have all the rights outlined in this Notice with respect to health information relating to reproductive healthcare, except in emergency situations or when the law requires reporting of abuse and neglect. In the case of abortion, if a parent provides consent to your abortion, the parent has all the rights outlined in this Notice, including the right to access the health information relating to abortion. If you are a minor or a person with a guardian obtaining healthcare that is not related to reproductive health, your parent or legal guardian may have the right to access your medical record and make certain decisions regarding the uses and disclosures of your health information.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in our facility. The Notice contains the effective date on the first page. In addition, each time you register for treatment or healthcare services, we will offer you a copy of the current Notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact "The Privacy Official at PPLA." All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain the records of the care that we provided to you.

1057 Kingston Ave., Los Angeles, 90033
 560 S. St. Louis St., Los Angeles, 90033
 916 W. Burbank Blvd., M, Burbank, 91502
 21001 #9 Sherman Way, Canoga Park, 91303
 8520 So. Broadway, Los Angeles, 90003
 4786 ½ N. Peck Rd., El Monte, 91732
 1014 ½ N. Vermont, Los Angeles, 90029

(323) 226-0800
 (323) 226-0800
 (818) 843-2009
 (818) 843-2009
 (323) 226-0800
 (626) 443-3844
 (323) 226-0800

5525 E. Del Amo Blvd., Lakewood, 90713
 1550 N. Garey Ave., Pomona, 91767
 1316 3rd St. Promenade, #201, Santa Monica, 90401
 14623 Hawthorne Blvd., Ste 300, Lawndale, 90260
 7100 Van Nuys Blvd., Ste 108, Van Nuys, 91405
 7655 Greenleaf Ave., Whittier, 90602

(562) 866-0556
 (909) 620-4268
 (310) 787-2666
 (310) 787-2666
 (818) 843-2009
 (562) 866-0556

**REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF
 NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES**

DATE: _____ PATIENT #: _____

NAME OF PATIENT: _____

DATE OF BIRTH: _____ TELEPHONE #: _____

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 understand that I have the right to receive free language interpreter services. I understand that I must tell the staff if these services will be helpful to my understanding of the written or spoken information given during my health care visits.

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 described in Planned Parenthood Los Angeles' Notice of Health Information Privacy Practices. I consent to the use and disclosure of my health information as described in Notice of Health Information Privacy Practices.

PPLA is a teaching institution, and a person in training, under strict supervision may deliver/perform some components of my care. I have been informed and agree to such participation. Patient Initials _____

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).

I hereby acknowledge receipt of Planned Parenthood Los Angeles' notice of health information privacy practices (HIPAA 001).

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
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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 _____

Welcome to Planned Parenthood Los Angeles
Please complete this form to help us better serve you.

Is this your first visit to Planned Parenthood Los Angeles? Yes No

Reason for your visit: _____

Do you have an appointment? Yes No Time _____:

(For Women Only) Date of last normal period ____/____/____

_____, _____, _____
Last Name First Name Middle

_____, _____, _____, _____ Sex: Female
Alias (Other names used) Social Security # Date of Birth Male

_____, _____, _____
Street Number Street Name Apt. Number

_____, _____, _____, _____
City State Zip Code Primary Telephone Number

(_____) _____
Secondary Phone Number

WHAT LANGUAGE DO YOU PREFER TO SPEAK?:

- English Spanish Vietnamese Cambodian Hmong Chinese Armenian Arabic
- Russian Tagalog Japanese Hindustani Korean Laotian Sign Language
- Punjabi Portuguese Other

HOW SHALL WE IDENTIFY OURSELVES WHEN WE CONTACT YOU?

Planned Parenthood Doctor's Office Code Name: Ask staff for code name

WHAT IS YOUR RACE / ETHNICITY?:

- American Indian or Alaskan Native Native Hawaiian or Other Pacific Islander Black or African American
- White Filipino Chinese Korean Japanese Other Asian Other

Are you Hispanic? YES NO

HOW DID YOU HEAR ABOUT PLANNED PARENTHOOD LOS ANGELES? (CHOOSE ONE):

- Education Program¹ Community Event²
· Presentation at my school · After school programs · Health or Community Fairs · Promotoras Workshop
· Someone at my school · Theater Presentations · Program at my workplace or on the street
- Friend³ Relative / Family⁴ Ad / Yellow Page / Flyer⁵ Saw the Clinic⁶
- My Doctor⁷ Internet / plannedparenthood.org⁸ Other Agency/Organization⁹ Other

* Planned Parenthood Los Angeles offers clients several Funding Programs that may cover all or some of your medical costs, please provide the following information to determine if you qualify for such programs or discounted rates:

Family Size (Self, Spouse, Children): _____ House Hold Income (before taxes): \$ _____/month

Do you have any of the following:

- teal/green "Health Access Program Card" (HAP) Medi-Cal Health Insurance

Check any reasons you cannot use your Medi-Cal or medical insurance today:

- Confidentiality (your family might find out) Share of cost or unmet deductible
- Insurance does not cover birth control Other _____

The information I have provided is true. I authorize Planned Parenthood Los Angeles to bill my insurance for services rendered, and I agree to pay for services not covered by my health insurance or reimbursed by a third party. I understand I am responsible to pay for services provided to me.

Sign Here: _____ Date: _____

HEALTH ACCESS PROGRAMS FAMILY PACT PROGRAM CLIENT ELIGIBILITY CERTIFICATION (CEC)

Client identification number

This form is the property of the State of California, Department of Health Services, Office of Family Planning, and cannot be changed or altered.

Please **print** answers to all questions. The questions about your family size, income, and health care insurance are to determine if you are eligible for Family PACT Program services.

- Providers must keep a copy of this form in the client's medical record. (See PPBI, Client Eligibility Certification Form Completion Section for code determinations.)
- **Code areas are for Provider use only.**

Do you currently receive Medi-Cal benefits or services? Yes No

Do you have a Medi-Cal Benefits Identification Card (BIC)? Yes No

BIC number	Issue date
------------	------------

Do you have health care insurance for family planning services? (Private insurance, Health Maintenance Organization (HMO), Managed Care Plan, Student Health Insurance, etc.) Yes No

Do we need to keep your family planning services confidential from your partner, spouse, or parent? How may we contact you if we need to talk to you about something? Yes No
Confidentiality

Provider Use Only—CODE

First name	Middle name	Last name	Suffix (Jr., Sr.)
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Is your current name the same as your name at birth? If no, print your name at birth below. Yes No

First name at birth	Middle name at birth	Last name at birth	Suffix (Jr., Sr.)
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Number of live births	County of residence	Provider Use Only—CODE	Nine-digit ZIP code
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Gender	Provider Use Only—CODE	Social security number	Mother's first name
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Date of birth (mm/dd/yyyy) / / _ _ _ _	Place of birth (county, if California)	Provider Use Only—CODE	State (if not California)	Provider Use Only—CODE	Country (if not USA)	Provider Use Only—CODE
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Race/ethnicity

1 <input type="checkbox"/> Asian	2 <input type="checkbox"/> Black	3 <input type="checkbox"/> Filipino	4 <input type="checkbox"/> Hispanic
5 <input type="checkbox"/> Native American	6 <input type="checkbox"/> Pacific Islander	7 <input type="checkbox"/> White	0 <input type="checkbox"/> Other

Primary Language

1 <input type="checkbox"/> Armenian	2 <input type="checkbox"/> Cantonese	3 <input type="checkbox"/> English	4 <input type="checkbox"/> Hmong	5 <input type="checkbox"/> Khmer/Cambodian
6 <input type="checkbox"/> Korean	7 <input type="checkbox"/> Tagalog	8 <input type="checkbox"/> Spanish	9 <input type="checkbox"/> Vietnamese	0 <input type="checkbox"/> Other

This information will be used to see if you are enrolled in any state health program. Information will also be used to monitor health outcomes and for program evaluation purposes. Your name will not be shared. Each individual has the right to review personal information maintained by the provider unless exempt under Article 8 of the Information Practices Act.

Complete eligibility information on reverse side.

Eligibility Determination: Please list all family members (self, spouse, and children) living in your household and supported by the family income. List the source of any earned or unearned income and the amount of income, including income from employment, self-employment, tips, commissions, pensions, social security, child and/or spousal support, ongoing insurance payments, disability, Veterans Affairs, unemployment benefits, etc.

Name	Relationship to You	Age	Source of Income	Gross Monthly Income (Before taxes or deductions.)
	(Self)			
Family size:			Total family income	\$

I declare under penalty of perjury that the information I have given on this form is true, correct, and complete. I understand that the giving of false information may make me ineligible for this program.

Signature (or mark) of applicant	Date	Signature of witness to mark or interpreter	Date
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FOR PROVIDER USE ONLY

Provider certification: Eligible for Family PACT Program
 Ineligible for Family PACT Program (Give applicant Fair Hearing Rights.)

Medi-Cal client eligible for Family PACT verified: Limited scope Unmet share-of-cost

Based upon the information provided by the applicant and according to state and federal requirements, I certify that the applicant identified on this Client Eligibility Certification is eligible to receive family planning services under the Family PACT Program. If ineligible, the client has received a copy of this form which includes the Fair Hearing Rights.

Print name	Signature	Date
Annual Certification: If client is decertified (no longer eligible)	Date	Reason code (see Provider Manual)

Fair Hearing Rights

Any applicant for, or recipient of, services under the Family PACT Program has a right to a hearing conducted by the Department of Health Services regarding eligibility or receipt of services. An applicant or recipient does not have a right to contest changes made to the eligibility standards or benefits of the Family PACT Program.

First level review: If you wish to appeal either your denial of eligibility or receipt of services, please send your name, telephone number, address, and reason why you are requesting a review to the **First Level Review address** below. A request for a first level review must be postmarked within 20 working days of the denial of eligibility or services. The Office of Family Planning may request additional information by telephone or in writing from the provider or the applicant before issuing a decision.

Formal hearing: You may appeal the decision of the first level review within five working days of your receipt of the decision of the first level review by sending your name, telephone number, address, and reason for the appeal to the **Formal Hearing address** below. At the hearing, you may be represented by a friend, relative, lawyer, or other person of your choice. A representative of the provider will be present to explain the reasons for denying eligibility. If you want an interpreter provided at the hearing, please specify the language in your letter requesting a hearing.

First Level Review

Office of Family Planning
 Department of Health Services
 714 P Street, Room 440
 P.O. Box 942732
 Sacramento, CA 94234-7320

Formal Hearing

Office of Administrative Hearings and Appeals
 Department of Health Services
 714 P Street, Room 1216
 P.O. Box 942732
 Sacramento, CA 94234-7320