

# PLANNED PARENTHOOD GREATER MEMPHIS REGION

## DEMOGRAPHIC DATA

Today's Date: \_\_\_\_\_

CHART NUMBER \_\_\_\_\_

Birthdate: \_\_\_\_\_

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

County: \_\_\_\_\_

Age: \_\_\_\_\_

SSN: \_\_\_\_\_

Sex: F / M

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Wk Phone: \_\_\_\_\_

How can we contact you? Phone/ Cell

Email

Email address: \_\_\_\_\_

Race: White Black Native American Asian Pacific Islander Other

Ethnicity: Hispanic Non-Hispanic

Marital Status: Married Single Divorced Partnered

Education Level: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

How did you hear about us? (Please choose one)

1-Other Clinic

2- Hospital/health agency

3-Private Doctor

4-Social/Church Agency

5-School

6-Other Patient

7-Family/Friend

8-Media

9-Hotline

10-Phonebook

11-Other Public Health Program

**Pregnancy Information:**

Number of Pregnancies: \_\_\_\_\_

Number of Births: \_\_\_\_\_

Number of Living Children: \_\_\_\_\_

**Emergency Contact:**

Who should we contact in case of an emergency ONLY?

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

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|  |
|  |



**REQUEST FOR SURGERY OR SPECIAL PROCEDURE 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 must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Planned Parenthood may need to refer me to another health care facility to provide the services necessary for my care.

Procedure/Service

Mifepristone medication abortion/ Ultrasound Examination/ RhoGam injection if indicated/ Lab work

I have been given information about the test(s), treatments, service(s)/procedure(s)/surgery to be provided, including the benefits, risks, possible problems/complications and alternate choices. I was given *written patient information* and/or a copy of the Planned Parenthood Client Information for Informed Consent sheet. It was reviewed with me.

I understand that with any service/procedure/surgery, there is also the possibility of side effects. 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 about the results from this service/procedure/surgery has been given to me. I know that it is my choice whether or not to have this service/procedure/surgery. I know that I can change my mind about receiving this service at Planned Parenthood at any time.

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.

If there is an unexpected complication during the service/procedure/surgery, I request and authorize the clinician and authorized Planned Parenthood staff to do whatever is necessary to preserve my health and welfare.

In the event I need more pain medication to safely continue or complete the procedure, I request and authorize Planned Parenthood staff to give me medications they believe necessary. This may include medications to reduce pain and/or anxiety. I understand

Planned Parenthood Greater Memphis Region  
2430 Poplar Avenue, Suite 100, Memphis, TN 38112 (901) 725-1717

every medication carries a small risk. I understand the clinician will only use medications if s/he believes it is clinically indicated.

I 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) and perform the service(s)/ procedure(s)/surgery listed above.

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 understand that confidentiality will be maintained as described in Planned Parenthood Greater Memphis Region's *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*.

**I hereby acknowledge** receipt of Planned Parenthood Greater Memphis' notice of health information privacy practices.

\_\_\_\_\_  
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/his behalf) received the above mentioned information and said she/he read and understood same.

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

Planned Parenthood Greater Memphis Region  
2430 Poplar Ave, Suite 100  
Memphis, TN 38112  
(901) 725-1717

**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 must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Planned Parenthood may need to refer me to another health care facility to provide the services necessary for my care.

I have been given information about the test(s), treatment(s), procedure(s), and 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 Greater Memphis Region's *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*.

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).

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2430 Poplar Ave, Suite 100  
Memphis, TN 38112  
(901) 725-1717

I hereby acknowledge receipt of Planned Parenthood Greater Memphis Region notice of health information privacy practices.

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 \_\_\_\_\_

# Planned Parenthood Greater Memphis Region

2430 Poplar Avenue, Suite 100

Memphis, TN 38112

(901) 725-1717

## Terms of Payment for Medication Abortion Services

(Please initial in the lines provided, only after you have read each statement)

\_\_\_\_ At the beginning of your consultation we will collect an initial fee of \$ 475.00

\_\_\_\_ After your sonogram is done the initial charge of \$ 475.00 can change to \$400.00, \$ 495.00, \$550.00 or \$625.00 according to what the sonogram determines your gestational time (if you are too far for the medical and choose to have the surgical procedure done).

\_\_\_\_ Your blood type will be determined in our laboratory. If your RH factor is negative, you will need to purchase a Rhogam shot. The cost of this shot is an additional \$ 50.00 if you are less than 13 weeks or \$125.00 if you are 13 weeks or more, which is due at the time of check-in and cannot be billed to your account.

\_\_\_\_ If the medical or surgical procedure is not completed, a fee of \$ 200.00 will be charged to cover for services rendered by our lab and sonogram technician. Any remaining balance will be refunded to you in 14 business days.

By signing this document you acknowledge that you have read and understood our Terms of Payment for Medication Abortion Services Policies and you agree with every term.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

|   |   |
|---|---|
| <input type="checkbox"/>  | <b>CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW</b> |
| 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 _____  |   |



# Planned Parenthood Greater Memphis Region®

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

To help serve you better, fill out to the best of your ability. Thank you.

1. What decision have you made regarding your pregnancy?

- I'm still undecided
- I want to continue the pregnancy
- I have chosen abortion as my best option

2. On a scale of 1 to 10, was this decision easy or difficult decision (Circle one):

E1    2    3    4    5    6    7    8    9    10D

3. Did you consider any other options? \_\_\_\_\_

4. Whose decision is it for you to have this abortion? \_\_\_\_\_

Have you discussed your decision with anyone? \_\_\_\_\_ If so, who? \_\_\_\_\_

Are they supportive of your decision? \_\_\_\_\_

Are you being forced or coerced to have this procedure? Yes \_\_\_\_\_ No \_\_\_\_\_

5. Does the man involved know of your decision? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, is he supportive of your decision? \_\_\_\_\_

6. Circle all the words that describe how you feel:

Relieved    Sad    Sure    Confident    Guilty    Calm    Confused    Happy    Numb

Ashamed    Resolved    Selfish    Angry    Peaceful    Anxious    Disappointed    Comfortable

Irritated    Grieving    Irresponsible    Hopeful    Nervous    Other: \_\_\_\_\_

7. What are your thoughts today about ending this pregnancy? \_\_\_\_\_

8. How do you think you will feel after an abortion? \_\_\_\_\_

9. Please check what concerns you TODAY (Circle all that apply)

- A. Not sure of decision of having an abortion
- B. Is this confidential?
- C. Your relationship with your partner
- D. Wondering how you'll feel emotionally afterwards
- E. Is this going to hurt?
- F. Possible effects in future pregnancies
- G. Complications during and after
- H. Birth control options
- J. Other \_\_\_\_\_

10. Have you ever been abused emotionally, physically or sexually? Yes \_\_\_\_\_ No \_\_\_\_\_

Staff Comments: \_\_\_\_\_

- Reviewed alternatives to Abortion (parenting & adoption)
- Discussed risks of surgical abortion (failure, incomplete, infection, hemorrhage, perforation, death)
- Discussed risks of medical abortion (failure, incomplete, infection, hemorrhage, birth defects, death)
- HIV test offered

\_\_\_\_\_  
Staff/ Counselor Signature

revised 11/2/09



Planned Parenthood  
Greater Memphis Region ®

**Acknowledge Of Fact Sheets**

DATE: \_\_\_\_\_ PATIENT #: \_\_\_\_\_

NAME OF PATIENT: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

**MEDICATION ABORTION**

**I have received and read the following fact sheets:**

- Client Information Mifeprex \_\_\_\_\_
- What to Expect after Taking Mifeprex \_\_\_\_\_
- Misoprostal \_\_\_\_\_
- Ultrasound \_\_\_\_\_
- Rh(o) Immune Globin \_\_\_\_\_
- Diclofenac \_\_\_\_\_

**Signature of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

I witness the fact that the patient received the above-mentioned information and said she/he read And understand it 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 \_\_\_\_\_

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Signature of Witness \_\_\_\_\_

Date \_\_\_\_\_