

Two Kinds of Abortions: Differences Between Abortion by pill and In-Clinic Abortion

	Medical abortion "abortion by pill"	In-Clinic abortion (D & C)
Eligibility	Any woman without medical contraindications who is less than 63 days since the last normal menstrual period (LMP) as determined by Planned Parenthood® ultrasound. (63 days is 9.0 weeks.)	Any woman without medical contraindications who is at least 42 days LMP by Planned Parenthood ultrasound (42 days is 6.0 weeks).
Method description	Medical abortion is a pregnancy termination that is achieved by taking two medications, one taken by mouth on the day of your visit and one inserted between your cheek and gum one to two days later. This causes the pregnancy to be expelled.	Surgical abortion is surgery performed in an outpatient setting. A doctor places a speculum in the vagina, and injects a local anesthetic into the opening of the uterus (the cervix). The cervix is then gradually stretched, and a plastic tube is inserted into the uterus. The tube is connected to a suction machine, and the uterus is emptied by suction. In the first trimester abortion can be performed in approximately 10 minutes.
Medications	Patients will take between 200 (or 800) mgs of mifepristone (also known as Mifeprex) by mouth, at the first visit. One to two days later they will place 4 small tablets of misoprostol between the cheek and gum. Patients are given Tylenol #3 for pain, phenergan for nausea, and an antibiotic to decrease the risk of infection.	Patients are given optional medications that may vary based on her unique medical situation. Patients usually take 800 mg. Ibuprofen and 10 mg. Valium. They are also administered a local anesthetic during the surgery, and usually take doxycycline home with them to prevent infection.
Number of visits to the health center	At least two: on the first day of a medical abortion there is an initial visit of approximately 90 minutes in length, and two weeks later a follow up visit of about 60 minutes.	At least one lengthy visit; and a follow up exam 3 weeks later – this visit can take approximately 60 minutes.
Number of ultrasounds	At least two vaginal ultrasounds.	Usually one: on the day of surgery.
Provider	A clinician provides most medical abortion services at PPAZ under the supervision of a physician.	A physician performs all surgical abortions at PPAZ.
What to expect	Patients can expect some cramping on day one, and much more cramping on the day they place the misoprostol in the mouth. Cramps generally subside within a day or two. Patients should expect a day or two of discomfort, and must have some support at home to tolerate the effects of the abortion. This method requires some patience and maturity.	Patients can expect moderate to very heavy cramping during the abortion procedure, and those cramps should subside within 20 minutes of the procedure, becoming mild to moderate. Cramps are generally gone within a day or two.
Common complications	Bleeding, cramping, nausea, and diarrhea are common, especially on the day of inserting misoprostol. Phenergan will be dispensed on Day One of taking Mifeprex to decrease these effects. Approximately one or two women in one hundred will require an aspiration to relieve cramping, bleeding, or the passing of large clots.	Brief cramping, and bleeding for a few hours up to a few weeks is not uncommon, but bleeding for a few days is most common. Approximately one or two women in one hundred will require a second aspiration to relieve cramping, bleeding, or the passing of large clots.
Rare complications	Failure to terminate the pregnancy occurs in less than 1% of cases. A small percentage of women experience heavy bleeding, requiring treatment. About 1/100,000 women die during or after Medication abortion. About 10/100,000 women die during a full term pregnancy. Rarely, patients may experience prolonged vaginal bleeding.	There is a failure rate of approximately 1% or less, in which the pregnancy is not terminated. Other complications may include cervical tearing, perforation of the uterus, allergic reactions to drugs, and very heavy bleeding requiring a treatment. Very rarely, blood transfusions, hysterectomy or death. About 0.1/100,000 (1 in a million) women die during or after a surgical abortion at 8 weeks gestation.
Other issues	May not use tampons for post-abortion bleeding. Patients who are at least 8 weeks at the first visit may see an embryo in the tissue and clots they pass, but most women do not. No sex for two weeks after Mife treatment.	Should use only pads, not tampons, for post-abortion bleeding. No sex, douching, or vaginal medications for two weeks after surgery.
Cost	The fee for both types of early abortion is \$900. A discounted price is offered for patients who pay in full on the day of service: that fee is \$450. Some insurance plans cover this service; check with your insurance company.	

Dos Tipos de Abortos: Diferencias entre el Aborto con Píldora y el Aborto en Clínica

	Aborto Médico “Aborto con Píldora”	Aborto en Clínica (D y C)
Elegibilidad	Cualquier mujer sin contraindicaciones médicas que lleve menos de 63 días desde su último periodo menstrual (UPM) normal, según el ultrasonido de Planned Parenthood. (63 días son 9.0 semanas)	Cualquier mujer sin contraindicaciones médicas que lleve por lo menos 42 días desde su último período menstrual (UPM) según el ultrasonido de Planned Parenthood (42 días son 6.0 semanas).
Descripción del Método	El Aborto Médico es la terminación del embarazo que se logra tomando dos medicamentos: uno por vía oral el día de su visita y uno que se coloca entre la mejilla y las encías, uno o dos días después. Esto causa que el embarazo sea expulsado.	El aborto quirúrgico es una cirugía que se lleva a cabo sin que la paciente tenga que ser internada. El médico coloca un espéculo en la vagina e inyecta una anestesia local en la apertura del útero (cervix). Luego, se estira el cervix gradualmente y se inserta un tubo de plástico en el útero. El tubo se conecta a una máquina de succión, la cual vacía el útero. Durante el primer trimestre el aborto puede llevarse a cabo aproximadamente en 10 minutos.
Medicamentos	En su primera visita, la paciente tomará entre 200 y 800 mg. de mifepristona (también conocida como Mifeprex por vía oral. Uno o dos días después se colocarán 4 tabletas pequeñas de misoprostol entre la mejilla y las encías. Las pacientes recibirán Tylenol #3 para el dolor, fenergan para la náusea, y un antibiótico para reducir el riesgo de infección.	Las pacientes reciben medicamentos opcionales, que pueden variar dependiendo de su situación médica personal. Las pacientes generalmente toman 800 mg. De Ibuprofeno y 10 mg. De Valium. Además, se les administra anestesia local durante la cirugía y por lo general llevan a su casa doxiciclina para prevenir infecciones.
Número de visitas al centro de salud	Por lo menos dos: el primer día de un aborto médico hay una visita inicial de aproximadamente 90 minutos de duración, y dos semanas después hay una visita de chequeo de aproximadamente 60 minutos.	Por lo menos una visita larga y un examen de chequeo 3 semanas después – esta visita puede tomar aproximadamente 60 minutos.
Número de ultrasonidos	Por lo menos 2 ultrasonidos vaginales	Por lo general uno, el día de la cirugía
Proveedor	En PPAZ una enfermera provee la mayoría de los servicios de aborto médico, bajo la supervisión de un médico.	En PPAZ un médico realiza todos los abortos quirúrgicos.
Qué se puede esperar	Las pacientes pueden esperar tener algunos cólicos el primer día y muchos más cólicos el día que se coloquen el misoprostol en la boca. Por lo general, los cólicos desaparecen en 1 o 2 días. Las pacientes deberán esperar tener uno o dos días de incomodidad y deberán tener apoyo en casa para poder tolerar los efectos del aborto. Este método requiere paciencia y madurez.	Las pacientes pueden esperar tener cólicos desde moderados hasta muy fuertes durante el procedimiento del aborto, los cuales disminuirán en un marco de 20 minutos, volviéndose de moderados a leves. Por lo general, los cólicos desaparecerán en uno o dos días.
Complicaciones comunes	Sangrado, cólicos, náusea y diarrea son complicaciones comunes, especialmente el día que se inserta misoprostol. Para disminuir los efectos, puede tomar Fenegran en el día que tome Mifeprex. Aproximadamente 1 o 2 mujeres de cada 100 requieren una succión para aliviar los cólicos, el sangrado o el flujo de coágulos grandes.	Los cólicos breves y el sangrado desde algunas horas hasta unas cuantas semanas no son complicaciones inusuales. Aproximadamente una o dos mujeres de cada 100 requerirán una segunda succión para aliviar los cólicos, el sangrado o el flujo de coágulos grandes.
Complicaciones poco comunes	El porcentaje de fracaso en la terminación del embarazo es menos del 1%. Un pequeño porcentaje de mujeres experimenta sangrado en abundancia, requiriendo tratamiento. Aproximadamente 1 de cada 100,000 mujeres muere durante o después del aborto médico. Aproximadamente 10 de cada 100,000 mujeres mueren después de un embarazo completo. En raras ocasiones, las pacientes tienen sangrado vaginal prolongado.	El porcentaje de fracaso en la terminación del embarazo es de 1% o menos. Otras complicaciones pueden incluir rasgado cervical, perforación del útero, reacciones alérgicas a los medicamentos y sangrado muy abundante que requiere tratamiento. Muy rara vez, transfusiones de sangre, histerectomía o muerte. Aproximadamente 0.1 de cada 100,000 (1 en cada millón) de mujeres muere durante o después de un aborto quirúrgico a las 8 semanas de gestación.
Otros Asuntos	No se puede usar tampones para el sangrado después del aborto. Los pacientes que están por lo menos en su octava semana de gestación en la primera visita podrían ver un embrión en el tejido fino y los coágulos que expulsan, pero la mayoría de las mujeres no lo ven. No podrá tener relaciones sexuales durante 2 semanas después del tratamiento con Mifeprex.	Para el sangrado después del aborto debe utilizar solamente toallas sanitarias y no tampones. No puede tener relaciones sexuales ni tomar medicamentos vaginales por dos semanas después de la cirugía.
Costo	La cuota para los dos tipos de aborto temprano es de \$900. Se ofrece un precio con descuento equivalente a \$450 para aquellas pacientes que paguen al contado el día del servicio. Algunos planes de seguro cubren este servicio, favor de contactar a su compañía de seguros.	

Client Information for Informed Consent

USING THE ABORTION PILL

Before you have the abortion, you need to know the most common benefits, side effects, risks, and alternatives. We have listed them here for you. We are happy to answer any questions you have.

“Abortion pill” is a popular name for a medicine called mifepristone. (Mifeprex® is the brand name.) It ends the pregnancy. It does this by keeping your body from making a certain hormone called progesterone. The pregnancy cannot go on without progesterone.

After you take the abortion pill, you will take a second medicine called misoprostol. It opens the cervix and makes the uterus contract. This empties the uterus and completes the process. The whole process is called medication abortion.

There are different ways to take these medicines. There is the way approved by the FDA. The FDA way is talked about in the Medication Guide and Patient Agreement. You will read these papers. You will need to sign the Danco Patient Agreement to show that you understand the FDA way. Alternative ways to take the medicines have been studied. They are also safe and effective. By choosing one of the alternative ways, you will take the abortion pill (Mifeprex®) in the office. Then you take the misoprostol pills at home. We will give you instructions, “How to Take Your Pills.” It is important to follow these instructions. The amount and timing of the pills used is different from the FDA way.

Benefits — Using the abortion pill together with misoprostol is safe and effective. At Planned Parenthood, it has worked about 98 out of 100 times. Women can use it in the first nine weeks (63 days) of pregnancy.

Side-Effects — They usually do not last long. They usually need little or no treatment.

- **Cramping is expected —** It will be most severe after you take the misoprostol. Milder cramps may last a day or two after that.
- **Bleeding is expected —** It will be heaviest soon after taking the misoprostol. You may bleed or spot for three to four weeks after the abortion. You can expect your next period in four to eight weeks.
- **Fever —** Having a temperature of 99-100°F is okay. It should only last a short time.
- **Other —** It is common to have diarrhea, nausea, vomiting, headache, dizziness, back pain, and tiredness. They usually lighten up three days later. They usually stop within two weeks.

Emotional reactions — A wide range of emotions is normal with abortion. Most women feel relief and do not regret their decision. Some women may feel sadness, guilt, and/or regret after an abortion, just as they may after giving birth. If you are not able to do your normal activities or are feeling bad after two weeks, call us. We can help or refer you to someone who can.

Risks — Using the abortion pill together with misoprostol is safe and effective. But there are risks with any medical procedure. Your risk depends on how healthy you are. If you are in poor health, your risk goes up. These are the possible risks of using this procedure:

- **Failure to end the pregnancy —** Sometimes the medicines do not end the pregnancy. But they may cause serious birth defects. You may need to take additional medicines or have an abortion in a clinic or a hospital if the pregnancy continues.
- **Incomplete abortion —** Sometimes some of the contents of the uterus are not emptied. This can cause too much bleeding, infection, or both. You may need an abortion in a clinic or a hospital if that happens. You may also need other tests or treatments.
- **Blood clots in the uterus —** Clots in the uterus may cause cramping and pain. You may need a surgical procedure if that happens.

- **Bleeding too much or too long** — To make it stop, you may need treatment. It might include medication or a suction procedure. In some cases, a blood transfusion is needed.
- **Infection** — Most infections are easy to treat with medicine. But there is a small chance that you may need an abortion in a clinic, to go a hospital, or to have surgery.
- **Allergic reaction** — Some women are allergic to the medicines that are used. Any medicine or drug can cause a serious reaction when used alone or with something else. It is important for you to let us know all the drugs that you are taking or that you are allergic to. This includes herbal drugs.
- **Death** — Death from medication abortion is very rare. The risk of death from a full-term pregnancy and childbirth is much greater.

Call us right away if you have:

- **Abdominal pain** — This includes feeling sick, being weak, having nausea or diarrhea, or throwing up. It should not last longer than 24 hours after you take the second medicine. Call us right away if they do. Any one of them may be a sign of a serious infection. Or it could be another problem, like ectopic pregnancy. (That is a pregnancy that grows outside the womb.)
- **Heavy Bleeding** — Call us right away if you soak through two thick, full-size sanitary pads every hour for two hours in a row. Or call us if you think your bleeding is too heavy. One out of every 100 women bleed so much that that they need a surgical procedure to stop it.
- **Fever** — Call us right away if you have a fever of 100.4°F or more if it lasts for four hours and it happens during the few days after you take the second pills. Fever that high can be a sign of serious infection. Or it could be another problem, like ectopic pregnancy.

We will give you instructions on how to take care of yourself during the abortion. We will give you a special telephone number to reach us if you have a problem. We will give you a time to return to Planned Parenthood® for a follow-up visit. The outcome of a medication abortion cannot be guaranteed. It is unlikely that you will need emergency medical care that cannot be provided at Planned Parenthood. If you do, however, you will be responsible for paying for it — even if Planned Parenthood refers you to another doctor or hospital because of a medical problem.

There are two alternatives to abortion. They are parenthood and adoption. We can discuss any of these options with you. And we can help you with whatever decision you make. There are alternatives to using the abortion pill. You can have the abortion done in a clinic. You can have it done in a hospital. Or you can go to another provider. You can have the abortion now or later in the pregnancy. But your risks get bigger the longer the abortion is delayed.

Your health is important to us. If you have any questions or concerns please call us during business hour, 1.800.230.PLAN (7526). For emergencies during non-health center hours call 602.277.2457 or in Tucson 520.791.3684. We are happy to help you.

Signature of Patient

Date

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

Signature of Witness

Date

PLACE PT LABEL HERE

FEMALE MEDICAL HISTORY / REVIEW OF SYSTEMS

Date: ___/___/___ Age: _____

PERSONAL HISTORY	
1. Are you being treated for any illness/condition now?	YES NO
If yes, what?	
2. Do you smoke cigarettes?	YES NO
If yes, how many per day?	
3. Do you drink alcohol?	YES NO
If yes, how often?	
4. Do you use street drugs?	YES NO
If yes, what?	
5. Do you use over-the-counter drugs?	YES NO
If yes, what?	
6. Do you take prescription drugs?	YES NO
If yes, what?	
7. Do you feel safe in your current relationship?	YES NO
8. Do you have concerns about domestic violence?	YES NO
9. Is anyone forcing you to have sex?	YES NO
STAFF COMMENTS:	
PREGNANCY HISTORY	
1. How many times have you been pregnant?	
2. Number of live births:	3. Number of living children:
4. Age of each child:	5. Number of premature:
6. Number of c-sections:	7. Number with birth defects:
8. Number of fetal death:	9. Number of abortions:
10. Number of miscarriages:	11. Number of ectopic:
12. Number of vaginal deliveries:	
13. Are you breast-feeding now?	YES NO
14. Do you have plans for pregnancy in the next year?	YES NO
STAFF COMMENTS:	
MENSTRUAL HISTORY	
1. What was the first day of last menstrual period? Date: ___/___/___	
2. Was this a normal period?	YES NO
3. Are your periods usually regular?	YES NO
4. How many days does your bleeding usually last?	
5. How many days are your cycles?	
6. Is your period usually: () light () medium () heavy	
7. At what age did your period begin?	
8. Do you have the following with your periods (check ✓ all that apply):	
() cramps () nausea () headaches () back aches	
() pre-menstrual tension () bleeding/spotting in between periods	
STAFF COMMENTS:	

CARDIOVASCULAR – Do you have or have you ever had:	
1. Swollen feet/legs?	YES NO
2. Varicose veins/phlebitis?	YES NO
3. High blood pressure?	YES NO
4. High cholesterol or fats?	YES NO
5. Heart disease, heart surgery, or heart murmur?	YES NO
6. Stroke or stroke-like symptoms?	YES NO
STAFF COMMENTS:	
GASTROINTESTINAL – Do you have or have you ever had:	
1. Frequent nausea/vomiting?	YES NO
2. Diarrhea on a regular basis?	YES NO
3. Blood in your stool?	YES NO
4. Stomach problems, bowel problems, or ulcers?	YES NO
5. Severe heartburn?	YES NO
STAFF COMMENTS:	
MUSCULOSKELETAL	
1. Do you ever have swollen/painful joints?	YES NO
2. How many times have you broken a bone?	
3. Do you have any sensory difficulties?	YES NO
STAFF COMMENTS:	
NEUROLOGICAL – Do you have or have you ever had:	
1. Migraines/severe headaches diagnosed by a Dr.?	YES NO
2. Visual changes not related glasses or contacts?	YES NO
3. Fainting when your blood is drawn?	YES NO
4. Seizure disorder/epilepsy?	YES NO
STAFF COMMENTS:	
ENDOCRINE	
1. Are you frequently thirsty for no reason?	YES NO
2. Do you have swelling in your neck?	YES NO
3. Do you have night sweats/ hot flashes?	YES NO
4. Do you have diabetes/gestational diabetes?	YES NO
5. Do you have thyroid disease?	YES NO
STAFF COMMENTS:	
ALLERGY / IMMUNOLOGY	
1. Do you have any allergies?	YES NO
2. Are you up to date with your rubella vaccination?	YES NO
STAFF COMMENTS:	

PLACE PT LABEL HERE

FEMALE MEDICAL HISTORY / REVIEW OF SYSTEMS

SEXUAL HISTORY	
1. Are you currently sexually active?	YES NO
2. When was the last time you had sex?	
3. Could you be pregnant now?	YES NO
4. How many sexual partners do you currently have?	
5. How long have you been with your current partner(s):	
6. How many partners have you had in the past 12 months?	
7. Do you have sex with: () men () women () both	
8. Do you participate in (check ✓ all that apply): () oral sex () vaginal sex () anal sex () outer course	
9. At what age did you first start having sex?	
10. Do you have sexual concerns?	YES NO
STAFF COMMENTS:	
FAMILY HISTORY	
Family history not available <input type="checkbox"/>	
Has your biological family (mother, father, brother, sister) had any of the following (circle all that apply):	
Diabetes	MOTHER FATHER BROTHER SISTER
High blood pressure	MOTHER FATHER BROTHER SISTER
Stroke before age 55	MOTHER FATHER BROTHER SISTER
Heart disease before 55	MOTHER FATHER BROTHER SISTER
High cholesterol or fats	MOTHER FATHER BROTHER SISTER
Breast cancer	MOTHER FATHER BROTHER SISTER
Ovarian cancer	MOTHER SISTER
STAFF COMMENTS:	
BIRTH CONTROL	
1. Are you currently using a birth control method?	YES NO
If yes, what?	
2. What birth control method do you desire?	
3. If you have ever used birth control in the past, please list:	
Type of birth control	When used
	Problems, if any
STAFF COMMENTS:	

GENITOURINARY	
1. Have you had urinary tract, bladder, kidney infections or diseases?	YES NO
2. Do you have pain or bleeding with sex?	YES NO
3. When was your last Pap smear? Date: / /	
4. Have you ever had an abnormal Pap smear?	YES NO
If yes, when?	
5. Have you had any of the following (check ✓ all that apply): () colposcopy () cryosurgery () laser () LEEP () endometriosis () fibroids () ovarian cysts	
6. Have you had any of the following (check ✓ all that apply): () chlamydia () gonorrhea () genital warts () herpes () syphilis () PID () HIV	
7. Did your mother take DES when she was pregnant with you?	YES NO
STAFF COMMENTS:	
HEMATOLOGICAL / LYMPHATIC	
1. Have you ever had a breast lump or discharge from your nipples?	YES NO
2. Do you have swollen glands under your arms?	YES NO
3. If you get cut, do you bleed excessively?	YES NO
4. Do you have frequent bruising for no reason?	YES NO
5. Have you ever been anemic?	YES NO
6. Do you have a blood clotting disorder?	YES NO
7. Have you ever had breast surgery?	YES NO
8. Do you have a history of cancer?	YES NO
STAFF COMMENTS:	
RESPIRATORY	
1. Do you have lung disease (asthma, TB)?	YES NO
STAFF COMMENTS:	
PSYCHOLOGICAL	
1. Do you have depression, mental illness, or anxiety disorder?	YES NO
STAFF COMMENTS:	

I give the above information freely. It is complete and correct to the best of my knowledge. I understand that it is for Planned Parenthood® use only and will not be released to anyone else without my written permission unless ordered to do so by court order.

Patient Signature: _____

Date: _____

Medical Provider Signature: _____

Date: _____

Planned Parenthood Arizona
5651 N. 7th Street
Phoenix, Arizona 85014
1.800.230.PLAN (7526)

**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 Arizona'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).

I hereby acknowledge receipt of Planned Parenthood Arizona's 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

<input type="checkbox"/> CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW	
_____ Signature of any other person consenting	_____ Date
Relationship to patient _____	
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

PATIENT INFORMATION FORM

PLACE PT LABEL HERE

Last Name		First Name		Middle Initial	Nickname	
Social Security Number (XXX-XX-XXXX) - -		Birth Date (MM/DD/YYYY) / /		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		
Street Address				How do you prefer we contact you? <input type="checkbox"/> E-mail <input type="checkbox"/> Mail <input type="checkbox"/> Phone		
City		State	ZIP Code	County		
Race (check all that apply) <input type="checkbox"/> American Indian Or Alaska Native <input type="checkbox"/> Asian Or Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> Multiracial <input type="checkbox"/> Other <input type="checkbox"/> White		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic	Marital Status <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Significant Other <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed		Student Status <input type="checkbox"/> Full Time Student <input type="checkbox"/> Not a Student <input type="checkbox"/> Part Time Student	
Home Phone ()		Day Phone ()		Alternate Phone ()		
Emergency Contact Name		Emergency Contact Phone # ()		E-mail		
Family Income \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly		Family Size (the number of people supported by your income)				
Under Title X of the Public Health Services Act funds are available for some services at no cost or discounted based on your family income and household size. Do you want to be considered for this program? <input type="checkbox"/> YES <input type="checkbox"/> NO						
Full Family Planning Title X Service available at: Archer, Maryvale, Mesa, Yuma						
Minors: Reporting of sexual abuse or coercion to the appropriate authorities may be required.						
Confidentiality will be maintained except as mandated by state law.						
INSURANCE / AHCCCS INFORMATION						
Policyholder Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Significant Other <input type="checkbox"/> Spouse						
Policyholder Last Name		Policyholder First Name		Policyholder Social Security # - -		
Policyholder Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		Policyholder Address, City, State & ZIP <input type="checkbox"/> Same as patient			Policyholder Birth Date / /	
Policyholder's Phone Number ()						
Plan Name		Policy Number		Group Number		
Plan Address, City, State & ZIP				Contact Phone # ()		

I acknowledge that all of the above information is true and correct and that it has been furnished to this office with full knowledge. I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted and I will be bound by the signature as though I personally signed the claim. I also authorize the release of any medical information necessary. **I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES.** If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

Signature of Patient

Date

PLACE PT LABEL HERE

INSURANCE & TITLE X VERIFICATION

*Insurance/AHCCCS eligibility and verification of benefits must be performed for each patient encounter.
Title X eligibility must be performed every six months, along with a PIF update.*

Verification Date	Date of Service	Procedure or Service:	Is this a covered benefit under the members plan?
/ /	/ /	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Insurance effective on DOS?	Co-Pay Amount:	Co-Insurance Amount:	Has Deductible been met?
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Deductible amount:			_____
Does the procedure or service need prior authorization? <input type="checkbox"/> Yes <input type="checkbox"/> No			Prior authorization #: _____
If PPAZ is not in the member's network, does the patient have out-of network benefits?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments:			

Name of Insurance Representative spoken with to verify insurance: _____

Signature of Staff Verifying Insurance Information _____

TITLE X VERIFICATION / ELIGIBILITY

Title X Excluded Visit: Yes No ***IF "NO" complete the following:***

Title X Program Eligible: Yes No

Income Level: _____ Slide % _____

If Client income is less than 100% of FPL, client was encouraged to follow up with AHCCS / DES Yes No

Staff Signature: _____ **Date:** _____

ABORTION QUALIFIER CHECKLIST FOR MINORS

Pursuant to ARS - 36 - 2152 the following item qualifies this patient for an abortion.

- Parental Consent does not apply
- Parental Consent - signed PPAZ Parental Consent form on file
- Court Order - copy of Court Order on file
- Sexual Abuse - signed Sexual Abuse Certification on file (Physician must report and forward sample fetal tissue)
- Physicians Certification - copy of certification from physician that states a medical condition as described in ARS - 36 - 2152 (g2)
- Emancipated - copy of marriage license or military documents on file

Type of ID Shown: _____ **ID #:** _____

Staff Signature: _____ **Date:** _____