

PLACE PT LABEL HERE

**MALE 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:		
SEXUAL HISTORY		
1. Are you currently sexually active?	YES	NO
2. When was the last time you had sex?		
3. How many sexual partners do you currently have?		
4. How long have you been with your current partner(s):		
5. How many partners have you had in the past 12 months?		
6. Do you have sex with: ( ) men ( ) women ( ) both		
7. Do you participate in (check ✓ all that apply):		
( ) oral sex ( ) vaginal sex ( ) anal sex ( ) outer course		
8. At what age did you first start having sex?		
9. Do you have sexual concerns?	YES	NO
STAFF COMMENTS:		
HEMATOLOGICAL / LYMPHATIC		
1. Do you have liver disease, hepatitis or gall bladder disease?	YES	NO
2. Do you have a blood clotting disorder?	YES	NO
3. Do you have a history of cancer?	YES	NO
STAFF COMMENTS:		
RESPIRATORY		
1. Do you have lung disease (asthma, TB)?	YES	NO
STAFF COMMENTS:		

CARDIOVASCULAR – Do you have or have you ever had:		
1. Varicose veins/phlebitis?	YES	NO
2. High blood pressure?	YES	NO
3. High cholesterol or fats?	YES	NO
4. Heart disease, heart surgery, or heart murmur?	YES	NO
5. Stroke or stroke-like symptoms?	YES	NO
STAFF COMMENTS:		
GASTROINTESTINAL – Do you have or have you ever had:		
1. Stomach problems, bowel problems, or ulcers?	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. Do you have night sweats/ hot flashes?	YES	NO
2. Do you have diabetes/	YES	NO
3. 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

## MALE MEDICAL HISTORY / REVIEW OF SYSTEMS

<b>FAMILY HISTORY</b>				
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	<b>MOTHER</b>	<b>FATHER</b>	<b>BROTHER</b>	<b>SISTER</b>
High blood pressure	<b>MOTHER</b>	<b>FATHER</b>	<b>BROTHER</b>	<b>SISTER</b>
Stroke before age 55	<b>MOTHER</b>	<b>FATHER</b>	<b>BROTHER</b>	<b>SISTER</b>
Heart disease before 55	<b>MOTHER</b>	<b>FATHER</b>	<b>BROTHER</b>	<b>SISTER</b>
High cholesterol or fats	<b>MOTHER</b>	<b>FATHER</b>	<b>BROTHER</b>	<b>SISTER</b>
<i>STAFF COMMENTS:</i>				
<b>BIRTH CONTROL</b>				
1. Are you currently using a birth control method?			<b>YES</b>	<b>NO</b>
If yes, what?				
2. What birth control method does your partner(s) use?				
<i>STAFF COMMENTS:</i>				

<b>GENITOURINARY – Do you have or have you ever had:</b>		
1. Urinary tract, bladder, kidney infections or diseases?	<b>YES</b>	<b>NO</b>
2. Pain or bleeding with sex?	<b>YES</b>	<b>NO</b>
3. Any of the following (check ✓ all that apply):		
( ) chlamydia	( ) gonorrhea	( ) genital warts
( ) herpes	( ) syphilis	( ) HIV
4. Severe scrotal injury?	<b>YES</b>	<b>NO</b>
5. Fluid pocket inside scrotum (hydrocele)?	<b>YES</b>	<b>NO</b>
6. Hernia?	<b>YES</b>	<b>NO</b>
7. Undescended testicle?	<b>YES</b>	<b>NO</b>
8. Infection of the reproductive tract, testes, epididymis, vas deferens or prostate?	<b>YES</b>	<b>NO</b>
<i>STAFF COMMENTS:</i>		
<b>PSYCHOLOGICAL</b>		
1. Do you have depression, mental illness, or anxiety disorder?	<b>YES</b>	<b>NO</b>
<i>STAFF COMMENTS:</i>		

*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: \_\_\_\_\_

## **HIV TEST**

You have asked for an HIV antibody test. HIV, the human immunodeficiency virus, can cause AIDS — Acquired Immune Deficiency Syndrome. It is important for you to read and understand the following information before you are tested or counseled. If you would like more information about HIV/AIDS, please ask us. We can also help you if you need referral to other health care providers.

**You must be tested for the HIV antibody to tell if you have HIV.** Bodies respond to infection by making antibodies. It can take three months after infection for a body to make enough HIV antibodies to be detected. For a few people, it may take as long as six months. There are several ways to test for HIV antibodies. It can be done with samples of blood, urine, or saliva. There may be slight differences in the accuracy of tests. Talk to us about which test may be best for you.

If the results of the test are “positive,” it means that antibodies to HIV have been found in your body. All positive results are confirmed with another test before the results are given to you. If the results are “negative,” it means that no antibodies to HIV have been detected.

**All counseling, testing, and referrals services are confidential.** Confidential means Planned Parenthood ® will know your name. Some states require that HIV test results be kept separate from the client’s medical records. This means that HIV test results would not be included if the medical records were sent to another health care provider. Other states allow the results to be included in the medical record.

Anonymous testing means that a code instead of the clients name is used to record the test results. Some states do not permit anonymous testing. If you want an anonymous test, please tell us before filling out any papers.

### **ADVANTAGES OF TAKING AN HIV TEST**

**Knowing whether or not you are infected can be helpful:**

- People who know they have HIV can start medical treatment to slow the development of disease.
- People who know they have HIV can change behaviors that may infect others.
- People who have taken chances about getting HIV and find out that they don’t have it may be motivated to lower their risks.
- People who’ve lowered their risks for HIV and find that they are still uninfected may be motivated to stay low-risk.
- People who know whether or not they’re infected may be more careful about protecting themselves and others.

We will be happy to talk with you if you need more information about high-risk and low-risk behaviors.

**Getting samples for tests is easy:**

- Samples of urine or saliva can be taken with no pain or discomfort.
- Drawing blood from a finger or vein may cause slight pain and discomfort as the needle punctures the skin. A small bruise may also develop where the puncture takes place.

**DISADVANTAGES OF TAKING AN HIV TEST**

**No HIV antibody test is 100 percent accurate.**

There is a risk that the results may be inaccurate or inconclusive. The test may have been done too soon to detect antibodies. In rare cases, the test itself may be flawed. Inconclusive or inaccurate results can be very upsetting and frustrating. We are here to talk with you in this case.

**Knowing that they have HIV can have significant impact on people and the people they are close to.** That's why many states and cities have laws that prevent clinicians and employers from telling other people that a client or employee has HIV/AIDS.

**People who have or are thought to have HIV may be discriminated against.**

It is against federal law to discriminate against people with HIV/AIDS, or other disabilities, about jobs, housing, medical care, and in most places that are open to the public. Many states and cities have other specific protections for people who have or who are thought to have HIV/AIDS. But discrimination may yet occur in these or other circumstances.

**Although medical treatment may slow the development of disease, there is no cure for HIV/AIDS.**

**ALTERNATIVES**

There is a variety of HIV antibody screening tests. If we are unable to provide you with a specific test, we can refer you to other providers.

You may choose not to be tested but to get personalized counseling on reducing your risk of getting or transmitting HIV.

**SPECIAL INSTRUCTIONS**

Your health is important to us. You may be asked to return to the clinic to get your test results, have counseling, or obtain referral services. It is very important to keep this appointment. Please contact us if you cannot make the appointment or are seeing another health care provider.

**HOW TO AVOID GETTING OR TRANSMITTING HIV**

The Human Immunodeficiency Virus (HIV), which can cause AIDS, is not spread by contact such as touching, hugging, sneezing, coughing or kissing.

HIV is spread in blood, semen, breast milk, and vaginal secretions. The only way to be absolutely safe from getting HIV is by not having sexual intercourse (vaginal, anal or oral) and by not sharing needles and equipment to shoot drugs.

If you have any of the risk factors listed below, or if you aren't sure, you may want to have an HIV test or screening to find out if you have been infected. The following behaviors increase your risk of HIV infection:

- More than one sex partner (casual or steady);
- Sexual activities without protection (no condom, vaginal pouch, or dental dam) including vaginal, anal, and oral sex, both receptive and insertive activities;
- Sex with a person known to be HIV-positive;
- Sharing needles or having sex with persons who share needles;
- History of STI's and having sex with persons who have STI's especially genital lesions;
- Sex in exchange for drugs, money, or other inducements;
- Use of substances such as alcohol, cocaine, etc., in connection with sexual activity;
- Inconsistent condom use;
- Exposure to the following since 1978:
  1. Artificial insemination with untested donor semen;
  2. Blood or blood products transfusion (especially between 1978 and March of 1985);
  3. Tissue or organ transplantation (especially between 1978 and March of 1985);
  4. Unsterile tattoo, body piercing, scarification or other body decorating that may draw blood.

Women considering becoming pregnant, or planning to continue a pregnancy, may also wish to have an antibody-screening test. Anyone may get an antibody-screening test simply by requesting it.

If your test is negative, or if you decide not to take the test, your best protection is to not share needles, and to abstain from sex, or follow the "safer sex" suggestions.

**"Safer Sex" Suggestions**

Massage, hugging, body to body rubbing, friendly kissing (dry), touching your own genitals (masturbation), hand-to-genital touching (hand job), and mutual masturbation are safe activities that do not involve exchange of body fluids. The following is a summary of what the experts think.

<b>RISK CATEGORIES</b>	
<b>VERY LOW RISK</b> (No reported cases of HIV due to these behaviors):	
<ul style="list-style-type: none"> <li>• Masturbation - Mutual Masturbation</li> <li>• Touching - Massage</li> <li>• Erotic Massage - Body Rubbing</li> <li>• Kissing - Deep Kissing</li> <li>• Oral Sex on a Man with a Condom</li> </ul>	<ul style="list-style-type: none"> <li>• Oral Sex on a Woman with a Dental Dam, Plastic Wrap, or Cut-Open Condom</li> <li>• Avoid getting semen or blood into the mouth or on broken skin. Don't worry about getting vaginal secretions, menstrual flow, urine, or semen on unbroken skin away from the mouth or vulva.</li> </ul>
<p style="text-align: center;"><b><u>LOW RISK</u></b></p> (Rare reported cases of HIV due to these behaviors): <ul style="list-style-type: none"> <li>• Oral Sex</li> <li>• Vaginal Intercourse with a Condom or a Vaginal Pouch</li> <li>• Anal Intercourse with a Condom</li> </ul> Avoid getting semen or blood on broken skin or into the mouth, vagina or anus.	<p style="text-align: center;"><b><u>HIGH RISK</u></b></p> (Millions of reported cases of HIV due to these behaviors): <ul style="list-style-type: none"> <li>• Vaginal Intercourse Without a Condom</li> <li>• Anal Intercourse Without a Condom</li> </ul>

**RISK FACTORS (continued)**

<u>Some of the Drugs That Encourage Taking Risks with Sex:</u>	<u>Some of the Feelings That Encourage Taking Risks with Sex:</u>
<ul style="list-style-type: none"> <li>• Alcohol</li> <li>• Speed</li> <li>• Poppers</li> <li>• Marijuana</li> <li>• Cocaine</li> <li>• Crack</li> <li>• Ecstasy</li> </ul>	<ul style="list-style-type: none"> <li>• Desire to be Swept Away</li> <li>• Anger</li> <li>• Shame</li> <li>• Fear of Losing a Partner</li> <li>• Insecurity</li> <li>• Low Self-Esteem</li> <li>• Embarrassment</li> <li>• Need To Be Loved</li> </ul>

Limit the number of different sexual partners in your life. The more sexual partners you have, the greater the risk you run of getting HIV and other sexually transmitted infections (STIs).

Latex condoms, other barriers, and spermicides are not 100% safe, because they may fail and because people make mistakes. Only you can decide how much risk you want to take.

Remember that practicing some forms of very low-risk sex (skin to skin contact but no transmission of blood, semen, or vaginal fluids) does not eliminate your risk of acquiring other sexually transmitted diseases such as herpes, warts, pubic lice, and scabies.

If You take Intravenous Drugs

Do not use or share needles and equipment to take street drugs.

**HOW TO STERILIZE YOUR WORKS (NEEDLES AND SYRINGES)**

1. Pour some bleach in a cup and some water into another cup.
2. Pull bleach into the barrel of the syringe until it fills all the way up to the plunger, shake it a bit, and leave it in for a minute. Squirt it out into a sink or the toilet.
3. Pull water into the barrel of the syringe until it fills all the way up to the plunger and shake it a bit. Squirt it out into a sink or the toilet.
4. Repeat bleach, water, bleach, water for a total of 3 times with each. Rinse out with water one last time to be sure.
5. Wipe out the cooker or spoon with a bleach-soaked piece of cotton and then rinse with running water. Dry it off.
6. Do not share syringe or cooker without first cleaning them. Do not share cottons.

For more information, ask your clinician.

If both partners in a couple are HIV negative (if they both have had two negative antibody tests 6 months apart) and both do not have sex with others or share needles and equipment to shoot drugs, they may have unprotected sex with each other with very little risk of transmitting the AIDS virus.

If you have had sexual relations or shared needles or equipment with someone you think could have HIV, or if you aren't sure, you may want to have an HIV test to find out if you have been infected.

**HIV RISK & TESTING NEEDS ASSESSMENT**

**Have you been tested for HIV/AIDS before?**

- Yes
- No

Approximate date of last test: \_\_\_\_\_

**What parts of your body have you used to have sex? (Check all that apply):**

- Vagina
- Penis
- Anus
- Mouth
- Other: \_\_\_\_\_

**What parts of the body has your partner(s) used? (Check all that apply):**

Male Partners

- Penis
- Anus
- Mouth
- Other: \_\_\_\_\_

Female Partners

- Vagina
- Anus
- Mouth
- Other: \_\_\_\_\_

**Check any statements that are true for YOU (Check all that apply):**

- Had sex without a condom
- Paid/been paid for sex
- Had sex while under the influence of alcohol/drugs
- Had sex with someone who has HIV/AIDS
- Injected drugs/shared needles
- Tested positive for a sexually transmitted infection
- Spent time in prison
- Other risks: \_\_\_\_\_

**Check any statements that are true for YOUR PARTNER(S) (Check all that apply):**

- Had sex without a condom
- Paid/been paid for sex
- Had sex while under the influence of alcohol/drugs
- Had sex with someone who has HIV/AIDS
- Injected drugs/shared needles
- Tested positive for a sexually transmitted infection
- Spent time in prison
- Other risks: \_\_\_\_\_

**When was the last time you had sex?** \_\_\_\_\_ **Did you use condoms/dental dams?**  Yes  No

**How often do you and your partner(s) participate in the following? (Circle one):**

Abstain from intercourse	<b>Always</b>	<b>Sometimes</b>	<b>Never</b>
Commit to a faithful relationship with only one person	<b>Always</b>	<b>Sometimes</b>	<b>Never</b>
Use condoms with every sex act	<b>Always</b>	<b>Sometimes</b>	<b>Never</b>
Share needles	<b>Always</b>	<b>Sometimes</b>	<b>Never</b>

- CONTINUED ON THE BACK -

### HIV CONSENT & TEST RESULT

Please initial here if you would like a copy of this test result \_\_\_\_\_

**Informed Consent:**

*I have read and understand the patient information sheets **About AIDS and the HIV Antibody Test or Screening and How to Avoid Getting or Transmitting HIV**. I understand the difference between confidential and anonymous testing and that the testing I receive today is confidential. I have been advised what the HIV test or screening results mean and of the benefits and concerns of being tested or screened. I voluntarily consent to the withdrawal of blood and other bodily fluids from me as stated in the information sheets. Additionally, I understand a positive result may require additional confirmatory testing. I further understand that if my test result is positive, the information will be reported to the AZ Department of Health as required by law (Statute 36-604 & State Reg. R9-6-114). I understand that I do not have to be tested for HIV.*

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

**STAFF USE ONLY**

**Client Received:**

- Counseling only, testing declined
- Counseling and testing
- Client Information: HIV TEST
- HOW TO AVOID GETTING OR TRANSMITTING HIV
- UniGold HIV Test: Subject Information leaflet

**UniGold Test**

Date: \_\_\_\_\_ Test Lot #: \_\_\_\_\_ Test performed by: \_\_\_\_\_ Result: \_\_\_\_\_

Results given by: \_\_\_\_\_ (If Positive, Confirmatory Sample must be Obtained)

**Blood Serum Test**

**Check if Confirmatory Test**

Date: \_\_\_\_\_

Collected by: \_\_\_\_\_

Result: \_\_\_\_\_

Result Given by: \_\_\_\_\_



PLACE PT LABEL HERE

**POST-TEST EDUCATION: Information to be discussed if positive result:**

- Two Elisa and one Western Blot tests have been run: “Your result is positive, you have been exposed to HIV”.  
**(LONG PAUSE FOR THE INFORMATION TO SINK IN...)**
  
- Possible follow up questions: “How do you feel? Did you expect this result?”
  
- HIV disease is currently a manageable condition with proper medical evaluation. To help with your decision to start the current regimen of anti viral medications available you should first have your immune system evaluated with two tests. The first will be an immunocompetency profile (T-cell count), and the second a viral load test. This is not a death sentence by any means. As a result of the current medications available many people are living healthy and productive lives.
  
- Is there a current partner you should be notifying?
  
- County Health Department will be informed of this result and can help you with partner notification if you'd like.
  
- What were you planning to do the rest of the day? Who can you be with? Are you feeling at all unsafe? Do you need to speak with a counselor? Do you have the number of any hotlines/counselors/AIDS agencies?
  
- Counseling referral given
  
- Is there anything else you need from me today?

**COMMENTS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Staff 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

<b>Last Name</b>		<b>First Name</b>		<b>Middle Initial</b>	<b>Nickname</b>
<b>Social Security Number</b> (XXX-XX-XXXX) - -		<b>Birth Date</b> (MM/DD/YYYY) / /		<b>Sex</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	
<b>Street Address</b>				<b>How do you prefer we contact you?</b> <input type="checkbox"/> E-mail <input type="checkbox"/> Mail <input type="checkbox"/> Phone	
<b>City</b>		<b>State</b>	<b>ZIP Code</b>	<b>County</b>	
<b>Race</b> (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		<b>Ethnicity</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic	<b>Marital Status</b> <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		<b>Student Status</b> <input type="checkbox"/> Full Time Student <input type="checkbox"/> Not a Student <input type="checkbox"/> Part Time Student
<b>Home Phone</b> ( )	<b>Day Phone</b> ( )		<b>Alternate Phone</b> ( )		<b>E-mail</b>
<b>Emergency Contact Name</b>		<b>Emergency Contact Phone #</b> ( )		<b>How did you hear about Planned Parenthood® Arizona?</b>	
<b>Family Income</b> \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly			<b>Family Size</b> (the number of people supported by your income)		
<b>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?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO					
<b>Full Family Planning Title X Service available at:</b> Archer, Maryvale, Mesa, Yuma					
<b>Minors:</b> Reporting of sexual abuse or coercion to the appropriate authorities may be required.					
<b>Confidentiality will be maintained except as mandated by state law.</b>					
<b>INSURANCE / AHCCCS INFORMATION</b>					
<b>Policyholder Relationship to patient:</b> <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Significant Other <input type="checkbox"/> Spouse					
<b>Policyholder Last Name</b>		<b>Policyholder First Name</b>		<b>Policyholder Social Security #</b> - -	<b>Policyholder Birth Date</b> / /
<b>Policyholder Sex</b> <input type="checkbox"/> Female <input type="checkbox"/> Male		<b>Policyholder Address, City, State &amp; ZIP</b> <input type="checkbox"/> Same as patient			<b>Policyholder's Phone Number</b> ( )
<b>Plan Name</b>		<b>Policy Number</b>		<b>Group Number</b>	
<b>Plan Address, City, State &amp; ZIP</b>				<b>Contact Phone #</b> ( )	

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?

    /    /       /    /    \_\_\_\_\_     Yes     No

Insurance effective on DOS?    Co-Pay Amount:    Co-Insurance Amount:    Has Deductible been met?    Deductible amount:

Yes     No    \_\_\_\_\_    \_\_\_\_\_     Yes     No    \_\_\_\_\_

Does the procedure or service need prior authorization?     Yes     No    Prior authorization #: \_\_\_\_\_

If PPAZ is not in the member's network, does the patient have out-of network benefits?     Yes     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:** \_\_\_\_\_