Planned Parenthood®
Southeastern Pennsylvania

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 understand that a new Pennsylvania law requires PPSP to give me written notification if a serious event compromising patient safety occurs under specific circumstances and that this notification will be sent to the mailing address listed on my contact sheet.

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 Southeastern Pennsylvania'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 voluntarily request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, or HIV antibody test, if I request it).

I hereby acknowledge receipt of Planned Parenthood Southeastern Pennsylvania'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 s/he read and understood same and had the opportunity to ask questions.

Signature of Witness ____

Date ____

Planned Parenthood®
Southeastern Pennsylvania

Contact /Personal Information

Patient Number ______________________ Today's Date ______________

Name______________________________ Nickname ______________
First Last (optional)

Address_________________/_______________/_______/_______/
Street Apt# City State Zip

Is it O.K. for us to contact you by mail at above address? [ ]Yes [ ]No
If yes, can we use a Planned Parenthood envelope? [ ]Yes [ ]No
Address for mail, if different from the one above:

__________/__________________/__________/_____/_____/
c/o Name Street Apt# City State Zip

Can we use a Planned Parenthood envelope at this address? [ ]Yes [ ]No

Your Telephone numbers
Phone 1 (_____)_____________________(home) (work) (cell) Best time to call? _______
May we say "Planned Parenthood" to anyone who answers at this number? [ ] yes [ ] no; Code name:_________

Phone 2 (_____)_____________________ (home) (work) (cell) Best time to call? ________
May we say "Planned Parenthood" to anyone who answers at this number? [ ] yes [ ] no; Code name: _____________

Marital status: [ ] Married [ ] Not Married

Social Security Number __ __ __ - __ __ - __ __ __ __ [ ] Female [ ] Male

Birth Date __ __ - __ __ - __ __ __ __ Age ________ **Staff Use Only:** ID Verified: [ ] yes [ ] no

Referred By: How were you referred to us?
[ ] Other Planned Parenthood Site [ ] Drove/walked by Center [ ] Family/Friend [ ] Internet
[ ] Newspaper Ad [ ] CHOICE Hotline [ ] Doctor [ ] Yellow Pages
[ ] Program done by PPSP [ ] School/College [ ] Other_______________

Sometimes Planned Parenthood likes to contact patients for your suggestions or to give you information. May we:
[ ] Call to get your opinion over the telephone about your patient care experiences?
[ ] Send you information about Planned Parenthood from any of its departments in a Planned Parenthood envelope?
[ ] Please do not contact me for these purposes.

Who can we contact if unable to reach you or in case of emergency? (This information is legally necessary):

Name______________________________
First Last

Address____
Bldg # Street Apt# City State Zip

Phone Number (_____)__________
Does this person know you are here [ ] Yes [ ] No Relationship___________
Should we (1) use a Planned Parenthood envelope or (2) plain envelope (circle the appropriate number)
Is it (1) OK to say Planned Parenthood to anyone who answers or (2) should we only use Planned Parenthood when speaking to the contact person? (Please circle appropriate number)

What is the name of your family doctor?

Patient Name______________________________________ Patient Number___________________

The information below is for statistical use only. No person will be excluded from services at Planned Parenthood Southeastern Pennsylvania based on duration of residency, citizenship, national origin, race, sexual orientation, marital status, religion, color, sex, method of referral, or contraceptive preference. With Census 2000, the Federal government introduced the option for choosing multiple races. Please choose from the lists below.

What county do you live in:

[ ] Chester County, PA [ ] Delaware County, PA [ ] Montgomery County, PA [ ] Philadelphia County, PA

[ ] Other Pennsylvania County ________________ (which county?) [ ] Other State_____________ (which state?)

Race/ Ethnicity

[ ] (04) Asian
[ ] (01) Black/African-American
[ ] (03) Native American/Alaskan Native
[ ] (07) Pacific Islander/Native Hawaiian
[ ] (02) White
[ ] (08) Asian + Black
[ ] (09) Asian + Native American/Alaskan Native
[ ] (10) Asian + Pacific Islander/Native Hawaiian
[ ] (11) Asian + White
[ ] (12) Black + Native American/Alaskan Native
[ ] (13) Black + Pacific Islander/Native Hawaiian
[ ] (14) Black + White
[ ] (15) Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (16) White + Native American/Alaskan Native
[ ] (17) White + Pacific Islander/Native Hawaiian
[ ] (18) Asian + Black + Native American/Alaskan Native
[ ] (19) Asian + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (20) Asian + White + Native American/Alaskan Native
[ ] (21) Asian + Black + Pacific Islander/Native Hawaiian
[ ] (22) Asian + Black + White
[ ] (23) Asian + White + Pacific Islander/Native Hawaiian
[ ] (24) Black + White + Native American/Alaskan Native
[ ] (25) Black + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (26) Black + White + Pacific Islander/Native Hawaiian
[ ] (27) White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (28) Asian + Black + White + Pacific Islander/Native Hawaiian
[ ] (29) Asian + Black + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (30) Asian + Black + White + Native American/Alaskan Native
[ ] (31) Asian + White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (32) Black + White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (33) Asian + Black+ White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (05) Other or Unknown

Are you of Hispanic origin? [ ] yes [ ] no

What is your primary language? (if not English)

[ ] Albanian
[ ] Arabic
[ ] Bosnian/Croation
[ ] Cambodian
[ ] Cantonese
[ ] Chinese
[ ] Creole
[ ] Ethiopian
[ ] French
[ ] Greek
[ ] Hindi
[ ] Ibo
[ ] Laotian
[ ] Mandarin
[ ] Polish
[ ] Portuguese
[ ] Russian
[ ] Spanish
[ ] Tagalog
[ ] Turkish
[ ] Ukranian
[ ] Urdu
[ ] Vietnamese
[ ] American Sign Language

[ ] Other______________________ (which language?)

Are you a student: [ ] yes [ ] no

What is the highest grade you have completed (do not include the one you are in now)? ______
If you are in high school, middle school, junior high or elementary school, what is the name of your school?
____

Current Birth Control Method:

[ ] Birth Control Pills
[ ] Cervical Cap
[ ] Condom - female
[ ] Condom - male
[ ] Condom and Spermicide
[ ] Depo-Provera
[ ] Diaphragm
[ ] Implanon
[ ] IUD
[ ] Natural Family Planning / Fertility Awareness
[ ] NuvaRing
[ ] Patch (Ortho Evra)
[ ] Other
[ ] Spermicide
[ ] Sponge
[ ] Sterilization
[ ] None – pregnant
[ ] None – seeking pregnancy
[ ] None – not currently sexually active
[ ] None – not at risk of becoming pregnant
[ ] None – not interested or undecided

Planned Parenthood®
Southeastern Pennsylvania

Financial Assessment and Responsibility

Patient Name: ______________________________ Patient Number: ______________________ Date: ________________

The fees patients pay at Planned Parenthood are vital to allowing us to continue to provide services. However, there are a number of state, federal and private programs that allow us to discount the part of your services for which you are responsible. We ask the following questions to determine if you qualify for any discounts.

The financial information you provide will not result in denial of services.

If you choose not to answer the questions about your household income, we will not discount your services and you will be responsible for paying the full, non-discounted price today.

	Yes	No		Yes	No
I am female			I am pregnant OR have had my tubes tied		
I am between the ages of 18 and 44			I have private medical insurance* that covers contraceptives.		
I am a US Citizen or am a Permanent Resident with a Green Card			Submitting an insurance claim would violate my confidentiality or cause me harm		
I have a Social Security Number			I currently receive Medical Assistance OR SelectPlan for Women benefits		
I am a resident of Pennsylvania			I received Medical Assistance in the past 4 months		

I am employed. ☐ Yes ☐ No If Yes: I work ________________ hours per week and earn $_____________ per hour.
2: I work ________________ hours per week and earn $_____________ per hour.
3: I work ________________ hours per week and earn $_____________ per hour.

I am legally married and live with my spouse. ☐ Yes ☐ No OR I live with my partner ☐ Yes ☐ No
His/her salary – ***before taxes*** – is: $ ______________ ☐ weekly ☐ every two weeks ☐ monthly ☐ annually

I have children: ☐ Yes ☐ No. If Yes: (#) ________ children and __________ live with me.
I have financially dependent children / step-children. ☐ Yes ☐ No
One or more of them ☐ is working ☐ pays rent. If yes to either or both, total is $____________ per month.

I pay for child / adult dependent care so that I can work. ☐ Yes ☐ No
If Yes: The total I pay is $ __________ per month.

I have the following other sources of income: [check all that apply]
☐ child support / alimony $ __________ per month ☐ unemployment $ __________ per month
☐ worker's comp / disability $ __________ per month ☐ my children's income $ __________ per month

I am supported by the following. Check and complete if applicable.
☐ Parent(s) or legal guardian(s) earns $ __________ ☐ hourly ☐ weekly ☐ every two weeks ☐ monthly ☐ annually.
☐ Other (e.g. relative / roommate), please list: ___________________________________ earns $ __________________
.... ☐ hourly ☐ weekly ☐ every two weeks ☐ monthly ☐ annually.

Patient Name: ______________________________ Patient Number: ______________________ Date: ________________

ALL PATIENTS, PLEASE CHECK EACH BOX AND SIGN WHERE INDICATED:

☐ The information I have provided here is true and complete, to the best of my knowledge.

☐ I agree to provide documentation of any information I've reported here, if required.

☐ I may be assessed at each visit; my fee category may change if my circumstances or the fee scale changes.

☐ I understand PPSP will attempt to collect any unpaid balances.

Signature	Date

FOR PATIENTS WITH COMMERCIAL, MA, OR SP HEALTH INSURANCE ONLY. PLEASE READ EACH ITEM CAREFULLY:

☐ I am responsible for paying for any services not covered by my insurance, including co-pays, deductibles, uncovered services, or those provided when my coverage was not in effect. These fees may be charged by PPSP and/or independent labs.

☐ I authorize direct payment on my behalf from my insurance carrier(s) to PPSP.

☐ I authorize PPSP to submit my insurance information to an independent laboratory for any testing that I receive.

☐ Correspondence from my insurance company may be sent to the address of record for the policy, and that it may indicate what services were provided.

- Are you under another person's insurance? If so, please provide their full name:______________________________

OR:

☐ **DO NOT USE MY INSURANCE.** Using my insurance would breach my confidentiality, and I prefer to pay PPSP and/or an independent laboratory directly for all services I receive.

Signature	Date

►►►►► STAFF USE ONLY ◄◄◄◄◄

Date	Weekly Inc-Hhold Size (ex. 425-02)	Fee Category (ex. A-B or T-D)	SP Status (ex. Applied, Active, Denied, Ineligible)	Comments	Staff Initials

Reason for no SP app: ☐ Age ☐ Inc ☐ Ins ☐ MA ☐ C/I ☐ Res ☐ Pr/St ☐ Ref ☐ ID

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STI HISTORY & PHYSICAL

Patient Name:___________________________ **Age:**______ **Medical Record #:**____________ **Date:**____________

SUBJECTIVE/CHIEF COMPLAINT: Why are you here today? ☐ **Routine Screening** ☐ **Problem** ____________________

How do you identify? ☐ Female ☐ Male ☐ Transgender Other, please identify: ________________________________

No Yes

☐ ☐ Are you receiving medical care with another health provider? Reason for visit(s): ____________________________

☐ ☐ Are you allergic to any medications, metals, foods, anesthesia or other products? List: ____________________________

☐ ☐ Are you currently taking medications (including herbal remedies and vitamins)? List: ____________________________

FAMILY HISTORY – Has your Grandmother/father (GM/GF), Mother (M), Father (F), Sister (S), or Brother (B) been diagnosed with any of the following?

No Yes

☐ ☐ Breast cancer family member:____________
☐ ☐ Ovarian cancer family member:____________
☐ ☐ Uterine cancer family member:____________
☐ ☐ Prostate cancer family member:____________
☐ ☐ Testicular cancer family member:____________

PAST MEDICAL HISTORY – Have **YOU** been diagnosed or treated for any of the following:

No Yes

☐ ☐ Kidney / Urinary Tract problems or infections
☐ ☐ Genital problems / surgery
☐ ☐ Pelvic infection / PID
☐ ☐ Abnormal Pap smear
☐ ☐ Serious illness or hospitalization
☐ ☐ Vaccination for Hepatitis B

REVIEW OF SYSTEMS

No Yes

☐ ☐ Constitutional: Fever/Weight Change/ Fatigue
☐ ☐ Oral: Ulcers / Sores in your mouth
☐ ☐ Skin: Rash / Itching

HEALTH HABITS / SOCIAL HISTORY

No Yes Do you:

☐ ☐ Douche.
☐ ☐ Smoke: __________ cigarettes per day.
☐ ☐ Alcohol intake: __________ drinks per week.
☐ ☐ Drug use: daily / weekly / monthly.
Type ________________________________
☐ ☐ Alcohol and/or drugs cause problems in your life?
☐ ☐ Others concerned with your alcohol/drug habits?
☐ ☐ Afraid of your partner(s) / others?
☐ ☐ Parent(s) or guardian is aware of your visit (Only answer if under age 18.)

SEXUAL HISTORY

Date you last had sex ____________________________
# of sexual partners in last 30 days: ________________
# of sexual partners in last 12 months: ______________
# of partners in your lifetime: ______________________
Partner(s) – Check all that apply: ☐ Male ☐ Female ☐ Transgender ☐ Intersex
Kind of sex: (please indicate all that apply:
☐ Vaginal (Giver/ Receiver)
☐ Anal (Giver/ Receiver) ☐ Oral (Giver/ Receiver)

No Yes Do you or have you:

☐ ☐ Consistently use condoms/dental dams for safer sex?
☐ ☐ Ever exchanged sex for money or something else you wanted?
☐ ☐ Ever been forced to have sex?
☐ ☐ Ever had a partner that had more than 1 partner?
☐ ☐ Have any of your partners used IV drugs?

INTERVIEWER COMMENTS

CONTRACEPTIVE HISTORY

Current method of birth control: ____________________

MENSTRUAL HISTORY

☐ Check here if this section is not applicable.

When was the **1st day** of your last period? ____________

No Yes

☐ ☐ Was your last period normal?
☐ ☐ Do you think you might be pregnant?

STI HISTORY – Have you ever had the following?

No Yes

☐ ☐ Chlamydia Date last treated: ______________
☐ ☐ Gonorrhea Date last treated: ______________
☐ ☐ Herpes Date last treated: ______________
☐ ☐ HPV/warts Date last treated: ______________
☐ ☐ Syphilis Date last treated: ______________
☐ ☐ Trichomonas Date last treated: ______________
☐ ☐ HIV Date last treated: ______________
☐ ☐ Hepatitis Date last treated: ______________

STI TREATMENT

No Yes

☐ ☐ Are you here for STI treatment?
☐ ☐ Is your partner(s) being treated for an STI?
Date of treatment ________________________
Name of infection ________________________

HISTORY OF CURRENT COMPLAINT- Do you have any of the following?

No Yes

☐ ☐ Genital sores, itching or pain.
☐ ☐ Penile/Vaginal discharge.
☐ ☐ Scrotal/Testicular enlargement.
☐ ☐ Pain / bleeding with sex.
☐ ☐ Pain, burning, difficult or frequent urination.
☐ ☐ A fever or any flu-like symptoms.

Date symptoms first noticed: ________________________

I would like the following STI screening today:

☐ Chlamydia
☐ Gonorrhea
☐ HIV
☐ Syphilis

I would like information on the following:

Given (Staff Initials)

☐ Chlamydia __________
☐ Gonorrhea __________
☐ HIV __________
☐ HPV / warts __________
☐ Syphilis __________
☐ Breast Self Exam __________
☐ Testicular Self Exam __________

Patient Signature: ________________________________ **Date:** ________________

Interviewer Signature: ________________________________ **Date:** ________________

Patient Name:______________________ **Age:**______ **Medical Record #:**______________ **Date:**______________

Interviewer Notes:

☐ Safer sex and condom use reviewed
☐ ECP discussed
☐ HIV testing offered
☐ STI Risk Assessment done
☐ Pt. urged to discuss visit with parent/guardian

Interviewer Signature: ________________________________

OBJECTIVE:
Laboratory:

No	Yes		Pos	Neg
☐	☐	Chlamydia – Cervix /Urine /Urethra	☐	☐
☐	☐	GC – Cervix /Urine /Urethra	☐	☐
☐	☐	Herpes Culture	☐	☐
☐	☐	HIV	☐	☐
☐	☐	RPR	☐	☐
☐	☐	Other _________	☐	☐

Wet Mount: ☐ No ☐ Yes pH ______ WBCs ___________ Clue Cells ______
Whiff : ☐ Neg ☐ Pos ☐N/A Hyphae ______ Trich ______

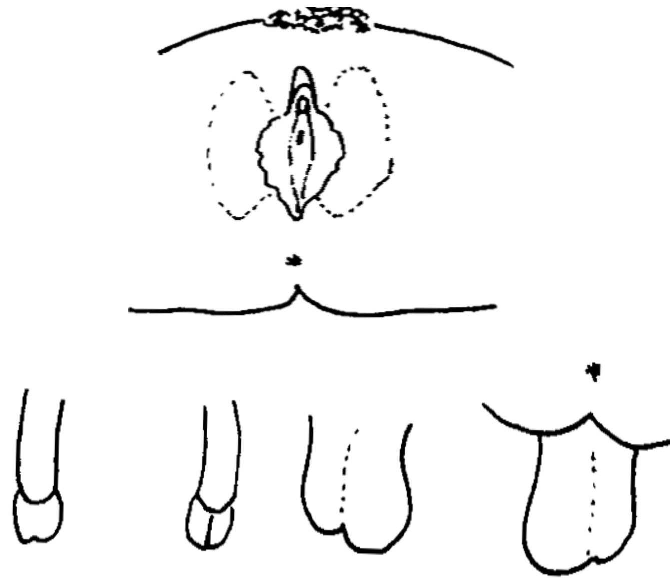
UTI Dipstick: Glucose _____ Protein _____ Nitrites _____ Leukocytes ______

Medical Examination:

1. Constitution:
   BP: ________ Temp: _______

	Normal	Variant	Not done
2. Skin	☐	☐	☐
3. Lymph	☐	☐	☐
4. Abdomen	☐	☐	☐
5. Genitourinary - Female			
Urethra	☐	☐	☐
Vulva	☐	☐	☐
Vagina	☐	☐	☐
Cervix	☐	☐	☐
Uterus	☐	☐	☐
Adnexa R	☐	☐	☐
L	☐	☐	☐
6. Genitourinary – Male			
Penis	☐	☐	☐
Scrotum	☐	☐	☐
Testes	☐	☐	☐
7. Gastrointestinal			
Rectal inspection	☐	☐	☐

8. Psychological – Acute distress ☐ No ☐ Yes



☐ Self- Testicular Exam Taught/ Pamphlet given ☐ N/A

ASSESSMENT AND PLAN:

☐ Pt. approved for UPT/STI Screen PRN
Pt. OK for ECP x 1 year: ☐ No ☐ Yes ☐ N/A
Plan B ________ LoOvral 8/Levlen 8 ________

☐ Spent >50% of time counseling. Total time with clinician ___________
☐ Implications of not obtaining follow up as recommended discussed
☐ Additional fact sheets/CIIC given _________________________________

Clinician Signature: _______________________________________ **Date:** ________________________