

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 _____

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

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

Are you of Hispanic origin? yes no

What is your primary language? (if not English)

- | | | | | |
|--|------------------------------------|-----------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Albanian | <input type="checkbox"/> Chinese | <input type="checkbox"/> Hindi | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Ukranian |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Creole | <input type="checkbox"/> Ibo | <input type="checkbox"/> Russian | <input type="checkbox"/> Urdu |
| <input type="checkbox"/> Bosnian/Croatian | <input type="checkbox"/> Ethiopian | <input type="checkbox"/> Laotian | <input type="checkbox"/> Spanish | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> French | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Tagalog | <input type="checkbox"/> American Sign Language |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Greek | <input type="checkbox"/> Polish | <input type="checkbox"/> Turkish | |
| <input type="checkbox"/> 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:

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

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. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No OR I live with my partner <input type="checkbox"/> Yes <input type="checkbox"/> No His/her salary – before taxes – is: \$ _____ <input type="checkbox"/> weekly <input type="checkbox"/> every two weeks <input type="checkbox"/> monthly <input type="checkbox"/> annually
I have children: <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes: (#) _____ children and _____ live with me. I have financially dependent children / step-children. <input type="checkbox"/> Yes <input type="checkbox"/> No One or more of them <input type="checkbox"/> is working <input type="checkbox"/> pays rent. If yes to either or both, total is \$ _____ per month.
I pay for child / adult dependent care so that I can work. <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: The total I pay is \$ _____ per month.
I have the following other sources of income: [check all that apply] <input type="checkbox"/> child support / alimony \$ _____ per month <input type="checkbox"/> unemployment \$ _____ per month <input type="checkbox"/> worker's comp / disability \$ _____ per month <input type="checkbox"/> my children's income \$ _____ per month
I am supported by the following. Check and complete if applicable. <input type="checkbox"/> Parent(s) or legal guardian(s) earns \$ _____ <input type="checkbox"/> hourly <input type="checkbox"/> weekly <input type="checkbox"/> every two weeks <input type="checkbox"/> monthly <input type="checkbox"/> annually. <input type="checkbox"/> Other (e.g. relative / roommate), please list: _____ earns \$ _____ <input type="checkbox"/> hourly <input type="checkbox"/> weekly <input type="checkbox"/> every two weeks <input type="checkbox"/> monthly <input type="checkbox"/> 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
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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
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▶▶▶▶▶ **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

PREGNANCY DETERMINATION

Patient Name: _____ Age: _____ Medical Record #: _____ Date: _____

SUBJECTIVE: Chief Complaint / Why are you here today? _____

No Yes

- Have you done a home pregnancy test? If yes, what was the result? _____
 If you are pregnant, what do you want to do? Abortion Adoption Parenting Undecided
 First day of your Last Normal Period: _____
 This period was: on time early late
 The amount of bleeding was: normal lighter heavier
 Are your cycles: regular irregular miss periods?
 Period come every _____ days.
- *Any bleeding or spotting since your last period?
 * Any lower abdominal pain or discomfort, shoulder or leg pain?
 When was your last act of intercourse? _____
- Did you use a method of birth control? Type: _____
 Are you having symptoms of pregnancy?
 Have you ever been pregnant?
 Age at first pregnancy _____ # of pregnancies _____ Date at end of last pregnancy _____
 Please indicate number and outcome of all previous pregnancies:
 Full Term Still Birth Abortion Miscarriage Tubal Pregnancy
- Have you ever had (check all that apply): Chlamydia *Infection after an abortion or delivery
 Gonorrhea *Infection of uterus or tubes (PID)
- Do you have any medical problems?
 Have you taken any medications in the last 48 hours?
 Have you ever been forced to have sex?
 Afraid of your partner(s) / others?
 Parent(s) or guardian is aware of your visit today? (Only answer if under age 18.)

Patient Signature: _____ Date: _____

FOR STAFF USE ONLY

OBJECTIVE:

Pregnancy Test Result: Negative Positive Weeks since LNMP: _____

Laboratory:

No Yes	Pos	Neg
<input type="checkbox"/> <input type="checkbox"/> Chlamydia – Cervix /Urine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> GC – Cervix /Urine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> HIV	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> RPR	<input type="checkbox"/>	<input type="checkbox"/>

ASSESSMENT / PLAN: Negative Pregnancy Test

No Yes

- Advised to return to center for repeat pregnancy test
 in 2-4 weeks if no menses
 Encouraged to return to center for complete GYN exam
 HIV risk assessment performed / screening offered
 Safer sex information offered
 Birth Control information offered
 Advised to see other medical provider
 Pt. encouraged to discuss visit with parent or guardian

Staff Signature & Title _____

Plan of Care Approval:

No Yes

- UPT/STI Screening PRN
 ECP (LoOvral 8/Levlen 8) x 1 year
 Rx Issued: _____
 Other _____

Clinician Signature: _____

Fact Sheets given:

- AIDS & HIV Antibody Test (N200)
 Emergency Contraception Pills (N51)
 Birth control CIIC, List #: _____
 Preconception Care (N75)
 Other: _____

Date: _____

FOR STAFF USE ONLY

Patient Name: _____ Age: _____ Medical Record #: _____ Date: _____

ASSESSMENT / PLAN: Positive Pregnancy Test

Patient plans: Abortion Adoption Parenting Undecided

Assessment of Decision-Making and Emotional Support

What do you feel about the pregnancy?

Notes: _____

Can you tell me about the support you have from your partner, family, or friends?

Notes: _____

ASSESSMENT / PLAN:

No Yes

- Client centered pregnancy options counseling offered
- Client informed about what to expect emotionally and physically before, during and after abortion, including that a range of emotions is normal.
- HIV risk assessment performed / screening offered
- Safer sex information offered
- Pt. encouraged to discuss visit with parent or guardian
- Patient advised to have pelvic sizing exam

Information/Facts sheets given:

- Ectopic precautions (N14)
- Having a Healthy Baby – Prenatal Care (N76)
- Adoption (N15)
- AIDS & HIV Antibody Test (N200)
- Pre-Abortion Instructions (N1000)
- About Your Abortion (N1027)
- Medical AB Q&A (N1047)
- Foster Care
- Other: _____

Referral form (NXXX) given for:

- Abortion counseling support (Backline, Exhale, Image)
- Abuse/Partner Violence
- Adoption
- Mental Health/Counseling
- Prenatal Care
- Sexual Assault/Rape
- 1st Trimester Referrals (N1005)
- 2nd Trimester Referrals (N1006)
- Other: _____

Staff Signature & Title _____

Date: _____