REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

DATE _______________ PATIENT # __________________________ DATE OF BIRTH ____________________

NAME OF PATIENT ____ 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.

Please note that Planned Parenthood Southeastern Pennsylvania is a teaching institution, and that persons in training, under strict supervision, may be involved in some aspects of your 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 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 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 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 she/he read and understood same and had the opportunity to ask questions.
Signature of witness ____Date ________________

☐	CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW

Signature of any other person consenting _____________________________Date______________

Relationship to patient ____Date ______________

I witness the fact that the patient's legal guardian (or person consenting in her behalf) received the above mentioned information and said she read and understood same.

Signature of witness ____Date ________________

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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:_________
May we text you? (charges may apply) [ ] yes [ ] no

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: _____________
May we text you? (charges may apply) [ ] yes [ ] no

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

N0804/0511

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 ALL PATIENTS WITH : PRIVATE INSURANCE (THAT YOU HAVE THROUGH YOUR JOB OR PAY FOR YOURSELF)
OR MEDICAL ASSISTANCE OR SELECTPLAN (INSURANCE PROVIDED BY THE STATE)

PLEASE READ EACH ITEM CAREFULLY, CHECK EACH BOX AND SIGN WHERE INDICATED:

☐ 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 their: ______________________________ ______/______/________
  Full Name Date of Birth

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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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
☐	☐	Chlamydia – Cervix /Urine	☐	☐
☐	☐	GC – Cervix /Urine	☐	☐
☐	☐	HIV	☐	☐
☐	☐	RPR	☐	☐

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

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:____________________________________

Staff Signature & Title______________________________ 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: ____________________________________