



**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 \_\_\_\_\_

**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? _____			
<i>May we say "Planned Parenthood" to anyone who answers at this number?</i> [ ] yes [ ] no; Code name: _____			
<i>May we text you? (charges may apply)</i> [ ] yes [ ] no			
Phone 2 (____) _____ (home) (work) (cell) Best time to call? _____			
<i>May we say "Planned Parenthood" to anyone who answers at this number?</i> [ ] yes [ ] no; Code name: _____			
<i>May we text you? (charges may apply)</i> [ ] yes [ ] no			
Marital status: [ ] Married [ ] Not Married			
Social Security Number _____ - _____ - _____		[ ] Female [ ] Male	
Birth Date ____ - ____ - _____ Age _____		<b>Staff Use Only:</b> 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? <b>(This information is legally necessary):</b>			
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<br>+ 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<br>+ 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<br>+ 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<br>+ Pacific Islander/Native Hawaiian        |
| <input type="checkbox"/> (14) Black + White  | <input type="checkbox"/> (32) Black + White + Native American/Alaskan Native<br>+ Pacific Islander/Native Hawaiian        |
| <input type="checkbox"/> (15) Native American/Alaskan Native<br>+ Pacific Islander/Native Hawaiian         | <input type="checkbox"/> (33) Asian + Black+ White + Native American/Alaskan Native<br>+ 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<br>+ 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.  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
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**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
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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



**Clinician Notes:**

Clinician Signature: \_\_\_\_\_

**OBJECTIVE:**

**Laboratory:**

No	Yes		Pos	Neg
<input type="checkbox"/>	<input type="checkbox"/>	Chlamydia – Cervix /Urine /Urethra	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	GC – Cervix /Urine /Urethra	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Herpes Culture	<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"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Wet Mount:  No  Yes pH \_\_\_\_\_ WBCs \_\_\_\_\_ Clue Cells \_\_\_\_\_  
 Whiff:  Neg  Pos  N/A Hyphae \_\_\_\_\_ Trich \_\_\_\_\_

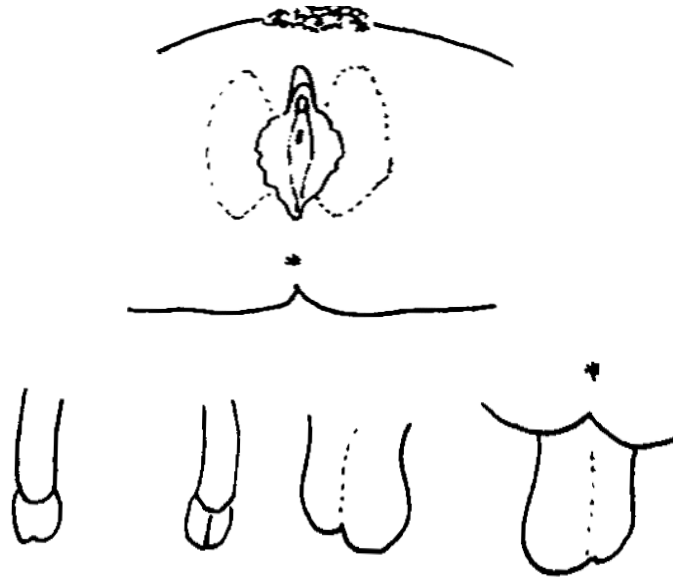
UTI Dipstick: Glucose \_\_\_\_\_ Protein \_\_\_\_\_ Nitrites \_\_\_\_\_ Leukocytes \_\_\_\_\_

**Medical Examination:**

1. Constitution:

BP: \_\_\_\_\_ Temp: \_\_\_\_\_

	Normal	Variant	Not done
2. Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Lymph	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. <u>Genitourinary - Female</u>			
Urethra	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vulva	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vagina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cervix	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adnexa R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. <u>Genitourinary – Male</u>			
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scrotum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Gastrointestinal			
Rectal inspection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Psychological – Acute distress	<input type="checkbox"/> No	<input type="checkbox"/> Yes	



Dorsal                  Ventral                  Anterior                  Posterior  
 Self- Testicular Exam Taught/ Pamphlet given     N/A

**ASSESSMENT AND PLAN:**

Discussed risks & benefits of \_\_\_\_\_

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: \_\_\_\_\_