Abortion Day Checklist

Patients and support person MUST have Government Issued Picture ID

- Bring Government Issued Picture ID
- Eat a meal before coming into the health center
- Wear a two piece comfortable outfit and underwear that will hold a maxi pad
- Plan on being in the health center for 3 ½ to 4 ½ hours (You may want to bring something to read to pass the time.)
- You may bring one support person (Must have Government Issued Picture ID)
- We request that you make childcare arrangements. Seating is limited and the long wait time is difficult for everyone.
- You MUST have a responsible adult come into the health center and get you, before you are discharged, if you are having an In Clinic Abortion and choose to have sedation.

Minors

Must Bring Picture ID

AND

Appropriate Below Mentioned Document(s)

Florida Law requires that at least one of your parents be notified of your decision to terminate your pregnancy. The easiest way to do this is to bring your Parent/Legal Guardian (with Valid ID) with you to your appointment. If they will not be accompanying you print the Parental Waiver, have your parent/legal guardian fill it out and have it Notarized and bring a photo copy of there ID. (Notary available at most of our health centers at no additional cost)

You MUST bring with you:

- A Picture ID or Yearbook with Picture and Name
- Notarized Parental Waiver
- Parent/Legal Guardians Government Issued Photo ID or copy of ID
- And your Birth Certificate OR Court Papers appointing Legal Guardianship

UNLESS

- You are, or have been married
  (Must bring picture ID and Marriage Certificate)
- You are emancipated
  (Must bring picture ID and court Emancipation Order)
- You have already given birth and child is dependent of you
  (Must bring picture ID and child’s birth certificate)
- OR, you receive a Judicial Waiver, an order from a judge that allows you to make the decision to have an abortion without notifying your parent or legal guardian.
  (For information on how to get a Judicial Waiver call the Health Center)
Request for Medical Services and Acknowledgement of Receipt of Notice of Health Information Privacy Practices

PLANNED PARENTHOOD OF SOUTHWEST & CENTRAL FLORIDA

MANATEE - SARASOTA - TAMPA - FT. MYERS - LAKELAND - WINTER HAVEN - PINELLAS
(941) 567-3800 (941) 953-4060 (813) 980-3555 (239) 481-9999 (863) 665-5735 (863) 269-7494 (727) 898-8199

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

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 understand that the information I will provide is true, accurate, and complete and that my healthcare choices will depend on that information.

I will be 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 will be told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in Planned Parenthood of Southwest and Central Florida, Inc.’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).

*Please note that Planned Parenthood of Southwest and Central Florida, Inc. is a teaching institution, and that persons in training, under strict supervision, may be involved in some aspects of your care.
I hereby acknowledge receipt of Planned Parenthood of Southwest and Central Florida, Inc.’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

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

Date/Fecha: ___________________________ 
Primary Care Physician/Medico Primario: ___________________________

"We will only contact you regarding your care; information will not be sold or used for solicitation purposes/ Sólo te contactaremos en cuanto a su cuidado; información no será vendida o utilizado para fines de solicitud"

Last Name/Apellido: ___________________________ First Name/Primer Nombre: ___________________________ M.I. ______

Marital Status/ Estado Matrimonial: _____________ Is this your legal name?/Es este su nombre legal? Y N

If not, what is your legal name?/Si no es cual es su nombre legal? ___________________________

Former Name/ Nombre Anterior: ___________________________ Age/ Edad: ___________

SSN/NSS: _______ - _______ - _______ DOB/Fecha de Nacimiento: _____ / _____ / _____ Sex/Sexo: F/M M/H

Address/Direccion: ___________________________ City/Ciudad: ___________________________

State/Estado: _______ Zip/Zona Postal: _________

Preferred Telephone/Telefono: (1) (______) ___________________________ (2) (______) ___________________________

Occupation/ Ocupacion: ___________________________ Employer/ Patron: ___________________________

Employer Phone Number/Numero telefonico del Patron: ___________________________

In Case of Emergency/En Caso de Emergencia

Name of local friend or Relative/ Nombre de un amigo local o Relativo: ___________________________

Relationship to Patient/ Relacion al paciente: ___________________________

Home Phone/ Telefono de Casa: ___________________________

Work Phone/ Telefono de su empleo: ___________________________

RACE/RASA (please circle one/por favor marque una):

African American /Africano Americano

Asian/Asiano

Multiracial/Multiracial

Native American/Indio Americano/ Nativo de Alaska

Pacific Islander/Isla Pacifica

White/Blanco

Other/Otra

Unknown/No Sabes

ETHNICITY/ETNICIDAD:

Hispanic/Hispano/Latino

Non-Hispanic/No-Hispano

HOW DID YOU HEAR ABOUT US?: COMO SUPO DE NOSOTROS?

(please circle one/por favor marque una):

BCC Online Appointment Social Services

Billboard Other funding Social Media

Community/Public Event Past PP Patient Source

Coupon Physician TV

Drove by Health Center PP Website Website

Educator Print Ad Yellow Page

Family/Friend Public Transportation Ad Yellow Pg-Web

Insurance Company Website Radio
<table>
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<tr>
<th>Person Responsible for Bill:</th>
<th>Birth Date:</th>
<th>Address (if different):</th>
<th>Home Phone:</th>
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<tr>
<td>Is this person a patient here?</td>
<td>Y   N</td>
<td>Is this patient covered by insurance?</td>
<td>Y   N</td>
</tr>
<tr>
<td>Employer Address:</td>
<td>Employer Phone:</td>
<td>Primary Insurance:</td>
<td>Subscriber’s Name:</td>
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<tr>
<td>Subscriber’s SS Number:</td>
<td>Birth Date:</td>
<td>Group no.:</td>
<td>Policy no.:</td>
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<tr>
<td>Copayment:</td>
<td>Patient’s relationship to subscriber:</td>
<td>Secondary Insurance (if applicable):</td>
<td>Subscriber’s Name:</td>
</tr>
<tr>
<td>Group no.:</td>
<td>Policy no.:</td>
<td>Patient’s relationship to Subscriber:</td>
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</table>

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize insurance company to release any information required to process my claims.

A lo mejor de mi reconocimiento la informacion dada aqui es verdadera. Yo autorizo mi seguro medico de que le page al medico directamente. Yo entiendo que es mi responsabilidad de pagar el balance. Yo tambien autorizo a la compania de seguro medico dar informacion necesaria para procesar el reclame.

Patient Signature/Firma del Paciente:

Date/Fecha: ____________________________

---

**PLANNED PARENTHOOD STAFF USE:**

DATE ______ ENTERED BY ______________________________ CHANGES NEEDED? Y   N

DATE ______ REVIEWED BY ______________________________ CHANGES NEEDED? Y   N

DATE ______ REVIEWED BY ______________________________ CHANGES NEEDED? Y   N
Consent for Treatment: I voluntarily consent to the rendering of care, including treatments, administration of anesthetics and performance of diagnostic and/or surgical procedure. I understand that I am under the care and supervision of the attending physician/clinician and it is the responsibility of the staff to carry out the instructions of such physician(s)/clinician(s). Initial __________

Assignment of Benefits: I hereby assign payment directly to Planned Parenthood of Southwest and Central Florida, Inc. which is accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician’s/clinician’s regular charges. I understand that I am financially responsible for the charges not covered by this assignment or for any and all charges for which the insurance carrier declines to pay. It is further agreed that any credit balance, resulting from payment of insurance or other services may be applied to any other accounts owed to Planned Parenthood of Southwest and Central Florida, Inc., by the insured or his/her family. Initial __________

Release of Information: The physician(s)/clinician(s) may disclose all or part of the patient’s record to any person or corporation which is or may be liable under a contract to the physician(s)/clinician(s) or the patient or to the family member or employer of the patient for all or part of the physician(s)/clinician(s) charges, including but not limited to, insurance companies, workers compensation carriers, welfare funds, or the patient’s employer. Initial __________

Medicare / Medicaid Certification – Payment Classification Authorization to Release Information and Payment Request: I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare, or third party claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s)/clinician(s) services. I understand that I am responsible for my health insurance deductible and co-insurance. Medicare / Medicaid only: Initial __________

To Our PPO, HMO, POS & Open Access Patients: If we are a participating provider of your health plan, we will bill your plan directly, but you are required to pay your deductible, co-payment, and/or coinsurance at the time of service. If your insurance company requires a referral, it is your responsibility to furnish this referral at time of service. Failure to do this may require you to reschedule your appointment and/or accept full responsibility for payment. Initial __________

To Our Patients with No Insurance: All charges are due and payable in full at time of service. We accept most major credit cards, debit cards, or cash. Initial __________

Patient Name (please print):
__________________________________________________________

Signature of Patient or Guardian:
__________________________________________________________

Date: ____________________
Date ______________ Age______________
May we say Planned Parenthood if we call? □ Yes □ No

□ Patient informed of required contact requirements.

Person to contact in an emergency: (cite relationship)
Name: __________________ Phone# (_____)____________________________
Relationship __________________ Phone# (_____)____________________________

Does this person know about your abortion? YES NO
First day of last normal menstrual period:______________________________
Was your last period normal? Yes ______ No___________

Pregnancy History:
Total times pregnant: #______ (Counting this pregnancy)
# of vaginal births ______ Date(s) __________________
# of C-sections ______ Date(s) __________________
# of Miscarriages ______ Date(s) __________________
# of ectopic (tubal) ______ Date(s) __________________
# of abortion(s) ______ Date(s) __________________
# of stillbirth(s) ______ Date(s) __________________
# of living children ______ Age(s) __________________

Which birth control method were you using when you became pregnant this time?
□ None
□ Condoms/foam/spermicides
□ Birth control pill
□ Diaphragm/cervical cap
□ Depo Provera injection
□ Tubal Ligation/vasectomy
□ Nuva Ring
□ IUD
□ Ortho Evra patch
□ Is it still in place? Yes ______ No________

Allergy History:
Are you allergic to or have you ever had a bad reaction to:

Allergies

Yes No (Please check YES or NO)
□ □ shellfish (iodine)?____________________________
□ □ latex or bananas? ___________________________
□ □ antibiotics (list below) _______________________________
□ □ Novocain or Lidocaine _______________________________
□ □ any type of anesthesia? _____________________________
□ □ antiseptic solution ________________________________

List other allergies:

Medications:
Do you use any of the following medications?

Yes NO (Please check YES or NO)
□ □ asthma inhaler?
□ □ steroids (like prednisone)?
□ □ blood thinners (like coumadin, heparin, etc)

List all other medications taken & their purpose:

Yes No (Please check YES or NO)
□ □ Do you smoke? If yes, #______ packs per day
□ □ Do you drink alcohol? If yes, #______drinks/week
□ □ History of drug addiction? Drug(s) __________________________

Do you use any of the following medications?

Medications:

□ □ Y

List:

Do you now have or have you ever had:

(please check YES or NO)

Yes No
□ □ Anemia / Sickle cell anemia
□ □ Blood clotting disease, like hemophilia
□ □ Leukemia OR any other blood problem
□ □ Asthma
□ □ Bronchitis / Pneumonia / Tuberculosis (circle)
□ □ Any other lung or breathing problem
□ □ Thyroid disease
□ □ Kidney (Renal) disease
□ □ Diabetes
□ □ Liver disease: Hepatitis/ Cirrhosis/ Mono/ Jaundice
□ □ Heart problems: heart attack/ surgery/ irregular heart beat/ mitral valve prolapse or: ______________
□ □ Epilepsy/ Seizure disorder
□ □ Inflammatory bowel disease/ Colitis/ Crohn’s Disease
□ □ Cancer_____________________
□ □ Breast lump
□ □ Stroke
□ □ Brain injury
□ □ Migraine headaches
□ □ Phlebitis / Blood clots in legs or lungs
□ □ High blood pressure
□ □ Depression/ Psychiatric problems
□ □ Fibroids of the uterus
□ □ Herpes
□ □ HIV/ AIDS
□ □ CURRENT Chlamydia or Gonorrhea Infection
□ □ Recent exposure to chlamydia or gonorrhea
□ □ CURRENT abnormal vaginal discharge
□ □ CURRENTLY breast feeding
□ □ CURRENT vaginal bleeding or pelvic pain
□ □ CURRENT cold symptoms and/or cough
□ □ Genetic condition /Chronic illness/ medical condition
□ □ Lupus or Antiphospholipid antibody syndrome

List:

List any hospitalizations, surgeries, accidents or injuries:

____________________________________________________

□ □ Yes □ No Have you ever been in the hospital overnight?
□ □ Yes □ No Have you ever had surgery?
□ □ Yes □ No Are you planning a surgery that will keep you in bed for a long time?

Does anyone in your family have:

Yes No Age at diagnosis
□ □ Breast cancer __________________________
□ □ Ovarian cancer __________________________
□ □ History of heart attack before 50 ___________
ABORTION VISIT – MEDICAL HISTORY FORM
Revised 07/12/13

☐ Yes ☐ No Has your partner ever messed with your birth control or tried to get you pregnant when you didn’t want to be?
☐ Yes ☐ No Does your partner refuse to use condoms when you ask?
☐ Yes ☐ No Have you ever been physically or emotionally abused by your partner or someone important to you?
☐ Yes ☐ No Have you been hit, slapped, kicked, or otherwise physically hurt by someone in the past year or, if you’re pregnant, since you’ve been pregnant?
☐ Yes ☐ No Has anyone forced you to have sex in the past year?
☐ Yes ☐ No Are you afraid of your partner?

I acknowledge that the above is correct & complete
Patient signature: __________________________________________ Date: ______

Staff signature: __________________________________________ Date: ______

Physician signature: ______________________________________ Date: ______

Staff comments if indicated:
DATE: _________________________

I hereby request and authorize Planned Parenthood:

☐ 736 Central Avenue, Sarasota, FL 34236  (941) 953-4060 ~ Fax: (941) 366-1899
☐ 1105 53rd Ave. East, Suite 201, Bradenton, FL 34203 (941) 567-3800 Fax (941) 753-3804
☐ 8068 N. 56th St., Tampa, FL 33617 (813) 980-3555 ~ Fax: (813) 341-1111
☐ 8595 College Pkwy. Suite 250, Ft. Myers, FL 33919 (239) 481-9999 ~ Fax: (239) 481-9346
☐ 2250 E. Edgewood Dr., Lakeland, FL 33803 (863) 665-5735 ~ Fax: (863) 665-4422
☐ 908 Havendale Blvd NW., Winter Haven, FL 33881 (863) 293-7494 ~ Fax: (863) 299-3485
☐ 8950 Martin Luther King Jr. St. N., St. Petersburg, FL 33702 (727) 898-8199 ~ Fax: (727) 898-9710

TO OBTAIN FROM:  MD/Clinic __________________________________ Phone: ________________________

Address __________________________________ Fax: ________________________

☐ Entire medical record or check appropriate box:
☐ Last annual exam information
☐ Pap and STI reports
☐ Colposcopy, cryotherapy, LEEP information
☐ HIV test results
☐ Biopsy reports
☐ Other (specify):  Related to Care Received at PPSWCF
☐ Except for the following which expressly may not be disclosed  (if none, write “none”):

From the medical records of:

NAME________________ PREVIOUS LAST NAME  (if needed)_____________________

(print or type)

FULL ADDRESS
_______________________________________________________________
_______________________________________________________________

DATE OF BIRTH      ________________  PHONE #  ______________  FAX # __________________

AUTHORIZATION MADE FOR THE FOLLOWING PURPOSE:
☐ At my request
☒ Specify:  For Continuation of Care

CONDITIONS OF AUTHORIZATION:
1. This Authorization will expire on (insert date or event):

2. I may revoke this Authorization at any time by notifying PPSWCF in writing, and it will be effective on
   the date notified except to the extent that PPSWCF has already acted upon such Authorization.

3. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the
   recipient and no longer protected by Federal privacy regulations.

4. By authorizing this release of information, my health care and payment for my health care will not be
   affected if I do not sign this Authorization form.

5. I have been offered a copy of this signed Authorization form.

SIGNATURE  ________________________  DATE  ______________

FOR OFFICE USE ONLY
Date Request Filled: ___________________   By: ________________________
Identification Presented: ________________   Form of Identification: ________________________
# PROBLEM LIST FORM

**PLANNED PARENTHOOD OF SOUTHWEST & CENTRAL FLORIDA**  
MANATEE - SARASOTA - TAMPA - FT. MYERS - LAKE LAND - WINTER HAVEN - PINELLAS  
(941) 567-3800 (941) 953-4060 (813) 980-3555 (239) 481-9999 (863) 665-5735 (663) 293-7494 (727) 896-6199  
Reviewed 09/12

Last/ First Name: __________________
Chart#: ________________________
D.O.B.:_________________________

### PROBLEM LIST

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**Notes/Updates**
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