Feminist Women's Health Center
Patient Privacy Notice Authorization

In order to comply with new federal guidelines outlined in the Health Insurance Portability & Accountability Act of 1996 (HIPAA), a Federal law which seeks to protect the privacy of consumers' healthcare information, we are advising you of your right as to how your medical information may be used.

The *NOTICE OF PRIVACY PRACTICES* located in the waiting rooms of the clinic outlines how personal information about you may be used and how you can get access to this information. If you would like a paper copy of the *NOTICE OF PRIVACY PRACTICES* please ask and we will be glad to provide you with one.

I have also been informed that any payment I make today is part of a global fee structure, which means that it is a discounted fee. Therefore, I may not file insurance at any time for reimbursement in relation to services I receive today. Furthermore, I understand and agree that the receipt for my payment today does not include an itemized statement and that the Feminist Women's Health Center is not obligated to issue itemized statements for services rendered.

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I authorize the Feminist Women's Health Center to communicate medical information pertaining to my care by the methods outlined in the *NOTICE OF PRIVACY PRACTICES*. I am aware that I may ask for a paper copy of the *NOTICE OF PRIVACY PRACTICES* at any time.

Client signature______________________

Witness______________________________

Feminist Women's Health Center
Request for Information

Please help us better serve you by filling out the information below; the questions on the next two pages are optional.

1. Please indicate your race:

- ☐ Asian Pacific Islander
- ☐ Asian/Asian American
- ☐ Bi-Racial (Other)
- ☐ Bi-Racial (Person of Color)
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ Multi-Racial (Other)
- ☐ Multi-Racial (Person of Color)
- ☐ Native American
- ☐ White/Caucasian
- ☐ Other/Unknown

2. Please indicate your primary language:

- ☐ Arabic
- ☐ Bosnian
- ☐ Cakchikel
- ☐ Chinese
- ☐ English
- ☐ French
- ☐ German
- ☐ Hindi
- ☐ Japanese
- ☐ Korean
- ☐ Mixtec
- ☐ Portuguese
- ☐ Punjabi
- ☐ Quiche'
- ☐ Russian
- ☐ Spanish
- ☐ Vietnamese
- ☐ Zapotec
- ☐ Other

3. Please indicate your religion:

- ☐ Agnostic
- ☐ Atheist
- ☐ Baptist
- ☐ Buddhist
- ☐ Catholic
- ☐ Christian
- ☐ Church of Christ
- ☐ Episcopalian
- ☐ Evangelist/Fundamentalist
- ☐ Hindu
- ☐ Jehovah's Witness
- ☐ Jewish
- ☐ Lutheran
- ☐ Methodist
- ☐ Mormon/Latter Day Saints
- ☐ Muslim
- ☐ Presbyterian
- ☐ Quaker
- ☐ Unitarian
- ☐ Wiccan
- ☐ Other

4. Please indicate any temporary or permanent physical challenges you may have:

- ☐ None
- ☐ Blind
- ☐ Breathing Impaired
- ☐ Deaf
- ☐ Limited Range of Motion
- ☐ Multiple Disabilities
- ☐ Mute
- ☐ Non-Ambulatory
- ☐ Other

5. Please indicate your relationship status:

- ☐ Divorced
- ☐ Widowed
- ☐ Married
- ☐ Partnered
- ☐ Legally Separated
- ☐ Single

6. Please indicate your national origin:

- ☐ Afghani
- ☐ African (Country Not Listed)
- ☐ American
- ☐ Asian (Country Not Listed)
- ☐ Bosnian
- ☐ Brazilian
- ☐ Carribean (Non-Puerto Rican)
- ☐ Chinese
- ☐ Colombian
- ☐ Cuban
- ☐ Declined To Indicate
- ☐ Egyptian
- ☐ Ethiopian
- ☐ Guatemalan
- ☐ Indian
- ☐ Iranian
- ☐ Iraqui
- ☐ Japanese
- ☐ Korean
- ☐ Mexican
- ☐ Middle Eastern (Country Not Listed)
- ☐ Moroccan
- ☐ Native American
- ☐ Nigerian
- ☐ Other
- ☐ Pakistani
- ☐ Puerto Rican
- ☐ Russian
- ☐ Salvadorian
- ☐ Somalian
- ☐ South African
- ☐ South American (Country Not Listed)
- ☐ Sudanese
- ☐ Thai
- ☐ Vietnames

7. Please indicate the combined annual income level for your entire household:

- ☐ Less than $12,250
- ☐ $12,251 - $15,500
- ☐ $15,501 - $20,750
- ☐ $20,751 - $25,000
- ☐ $25,001 - $29,250
- ☐ $29,251 - $33,500
- ☐ $33,501 - $37,750
- ☐ $37,751 - $42,000
- ☐ $42,001 - $50,000
- ☐ $50,001 - $75,000
- ☐ $75,001 - $100,000
- ☐ $100,001 - $150,000
- ☐ $150,001 - $200,000
- ☐ $200,001 - $250,000
- ☐ Greater than $250,000

8. Please indicate your sexual orientation:

- ☐ Bisexual
- ☐ Gay
- ☐ Heterosexual
- ☐ Lesbian
- ☐ Pansexual
- ☐ Queer
- ☐ Questioning
- ☐ Other

9. Please indicate the number of family members in your household, including yourself:

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ More than 10

10. Please indicate your level of education:

- ☐ Currently in Middle/High School
- ☐ Did Not Graduate High School
- ☐ High School Graduate/GED
- ☐ Two Year Undergraduate Degree
- ☐ Four Year Undergraduate Degree
- ☐ Post Graduate Degree

Please indicate how you found out about the Feminist Women's Health Center:

- ☐ Abortion Clinic Directory (online)
- ☐ Abortion Clinics Online
- ☐ Atlanta Latino
- ☐ Been Here Before
- ☐ Billboard
- ☐ Community Organization
- ☐ Creative Loafing
- ☐ Dekalb Rape Crisis Center
- ☐ Discount Coupon
- ☐ Friend
- ☐ Gay Yellow Pages
- ☐ Health Department
- ☐ Health Fair/Table
- ☐ In-Site Magazine
- ☐ Insurance Provider
- ☐ International Rescue Committee
- ☐ Mental Health Professional
  - Name: ____________________
  - Location: ____________________
- ☐ NAF Hotline
- ☐ Physician
  - Name: ____________________
  - Location: ____________________
- ☐ Planned Parenthood
- ☐ Refugee Family Services
- ☐ Refugee Women's Network
- ☐ Southern Voice
- ☐ Tapestri
- ☐ Website (FWHC)
- ☐ Yellow Pages
- ☐ Other Internet Ads/Listing
- ☐ Other: Please Specify: _________________

Feminist Women's Health Center's

Cliff Valley Clinic

Client Certification form

Today's Date, __/__/__

I, ____________________, request that an abortion be performed on me today,

Printed name

I certify that I am ______ years of age, date of birth ___/____/_____.

I certify that:

I do not chose to view the state materials as at least twenty-four (24) hours before the abortion, the physician who is to perform the abortion, the referring physician, or his or her qualified assistant has told me, by telephone, in person, or by automated script on Date, __/__/__ Time, _______

- The probable gestation of the fetus or embryo based on my last menstrual period
- The particular medical risks to me of the procedure that is indicated by my probable gestation
- The medical risks to me if I carry this pregnancy to term
- That medical assistance benefits may be available to me for prenatal care, childbirth and neonatal care
- That the father would be liable for child support per Ga. Code 19-7-49
- That I have the right to review State supplied materials, on the State of Georgia Website (or printed materials in the clinic at least 24 hours before my appointment) that describe the fetal development of the unborn child, contain information on fetal pain and contains a list of agencies that provide alternatives to abortion and that these materials are not available at this time
- I consent to the particular abortion freely and without coercion of any person and I am not under the influence of any drug of abuse or alcohol
- I was provided the opportunity to ask questions about the abortion that will be performed and all of my questions have been answered to my satisfaction

I verify that this information is correct and accurate.

Client's Signature____

Translator Signature____

Witness Signature ____

Physician Signature____

Or: I chose to view the State written materials which results in another mandatory 24 hour wait period. I will return to the clinic on the next available date _________ . Initials_________

Feminist Women's Health Center's
Cliff Valley Clinic
HB 147/Client Ultrasound Certification Form

Description
In accordance with the "Women's Ultrasound Right to Know Act" Chapter 9A of Title 31 Official Code of Georgia annotated, relating to the "Women's Right to Know Act", facilities performing abortions in the state of Georgia must offer each woman seeking an abortion the opportunity to view an active image of the ultrasound and to hear the fetal heart tones if they are present and audible.

The **choice is yours** whether to look at the ultrasound or listen to the fetal heart tones. You are not required to look or listen.

Attestation:
I was offered the opportunity to look at the ultrasound and to hear the fetal heart tones (if present) today, _______________.
DATE

I choose (check 1 box):
☐ **Not to look at** the sonogram ☐ **To look at** the sonogram

I choose (check 1 box):
☐ **Not to listen** to the fetal heartbeat ☐ **To listen** to the fetal heartbeat (if present)

I understand that this sonogram determines gestational age only and does not determine the presence or absence of any fetal malformation.

CLIENT SIGNATURE:_______________________ Date:___________
****
OFFICE USE BELOW THIS LINE

Fetal Ultrasound Report

# of Fetus: ☐ 0 ☐ 1 ☐ 2 ☐ 3

# of Sacs: ☐ 0 ☐ 1 ☐ 2 ☐ 3

YOLK SAC SEEN: ☐ YES ☐ NO

FHT: ☐ YES (B/M) ☐ NO ☐ NOT SEEN

FIBROID: ☐ YES PLACEMENT___________________________

PLACENTA: ☐ Anterior ☐ Posterior ☐ Fundal ☐ Previa

☐ Abdominal Ultrasound ☐ Transvaginal Ultrasound

HEIGHT: ____**ft** ____**in** **WEIGHT:** _______ **lbs.** **BMI:** _________

ULTRASOUND TECHNICIAN:________________________________

MD SIGNATURE:____

FEMINIST WOMEN'S HEALTH CENTER
MEDICAL HISTORY

Date ____/_____/______

Legal Name ____ Preferred Pronoun (he/she/ze) ___________
Preferred Name____________________________________ DOB _____/____/_____ Age ________
Address ____ Apt # ________ Phone (h) (____)_____-________
City _________________________ Within City Limits: Yes ( ) No ( ) (w) (____)_____-________
County _______________________ State __________ Zip _________ (c) (____)_____-________
At what phone # may we contact you?_______________________ May we leave a message: Yes ( ) No ( )
Emergency contact: Name ____
Address ____ Apt # ________ Phone (h) (____)____-_________
City _____________________________ State __________Zip _________ (w) (____)____-_________
Years of Education: _____________Language you speak: English, Spanish, French, Other____________________
Can you read/understand English to fill out this form: Yes ( ) No ( )
If not English speaking, Interpreter's name ____
Pharmacy # ____ Religion ___________________________
DRUG ALLERGIES: _________________________________ FOOD ALLERGIES: ______________________
CURRENT MEDICATIONS: ____

Please circle Y for yes or N for no, or fill in the space for the following questions:

Contraceptive History (Birth Control):

1. Y N Do you need/want birth control method/information. If you answered NO, skip to # 7.
2. Y N Is this a non-abortion visit and you are having intercourse/ risk for pregnancy
3. Current method of birth control used: _________________________________
4. How long using this method; ____________ Problems: Y N
   Describe: ____
5. **What method do you want to use now?** ______________________________
6. Methods used in past: (circle): Pills / Patch / Ring / Shot / Norplant / IUD / condoms / cervical cap / diaphragm / foam / gel / sponge / abstinence / withdrawal / sterilization / tubes tied / vasectomy / rhythm / Natural Family Planning / Emergency Contraception / other _______________

Sexual History/ Information: this information helps us with your care:

7. Age of first sexual experience ____Currently in sexual relationship: Y N
   Partner(s): men / women / both now ( ) always ( )
   Do you have more than one partner? Y N
   # partners in last year: _____Do you practice safe sex Y N
   Need information on safe sex Y N
   Recent change in partner Y N vaginal / oral / anal sex
   Partners History (circle all that apply):
   Has other partners, has same sex partners
   is a hemophiliac, is HIV+/ has AIDS
   uses recreational drugs

Social History:

Circle Y for yes or N for no to the following indicating your recent experience:

8. Y N Death of family member/friend
9. Y N Emotional/relationship problems
10. Y N Job loss/financial problems
11. Y N Problems in living arrangements/schools
12. Y N Legal problems/arrests/divorce
13. Y N Parental problems
14. Y N Has anyone forced you to have sex
15. Y N Are you afraid of your partner/family member
16. Y N Do alcohol/drugs cause problems in your life?
17. Y N Have you ever abused alcohol? Yes ( ) No ( ) Drugs? Yes ( ) No ( )
18. Y N Emotional/mental illness? Anti-Depressive, anxiety or psychotic medications?
19. Y N Do you feel you are in an abusive relationship?
20. Y N As a child did anyone touch your private body parts or ask you to touch theirs?
21. Y N Would you like referrals for any of the experiences above or do you need a counselor?
22. Y N Do you smoke? How many cigarettes/day ___________
23. Y N Do you drink? How much alcohol do you drink per week __________________
24. Y N Do you use recreational drugs? What kind? _________________________________ Date of last use__________________

Comments - Staff Only

21. Referrals provided?
Y N

Comments - Staff Only

25. Who helps and supports you with your problems ________________________
26. Who do you live with __________________

OB History:

Complete below:

27. Total No. Pregnancies including current: _______ Living children: _______
    Live births: ______ Miscarriages: ______ Abortions: _______
    Ectopic/tubal: ____ Other: _____________________________
    # of C-sections: ________ Last pregnancy when: __________
    Problems with pregnancies: (high blood pressure, seizures, toxemia, gestational diabetes, birth defects) other: __________________
28. **Are you Rh neg: Y N Have you received Rhogam: Y N**
29. Y N Trouble getting pregnant/staying pregnant
30. Y N Used fertility treatments/medications
31. Y N Had artificial insemination (s)

Personal Medical History:

Circle Y for yes or N for no to the following and circle items that apply: (Current & Past)

32. Y N Eye/vision problems, glasses/contacts
33. Y N Deaf/Mute. Do you know sign language Yes ( ) No ( )
34. Y N Heart problems/palpitations/murmurs/surgery/MVP (Mitral Valve Prolapse)
35. Y N High Blood Pressure
36. Y N Strokes/Blood Clots in head, heart, brain/Head injury
37. Y N Varicose veins
38. Y N High cholesterol/ blood fats
39. Y N Diabetes/High Sugar: (insulin/diet /oral/) Only with pregnancy
40. Y N Bladder/Kidney problems/infections
41. Y N Headaches/migraine, stress related or other
42. Y N Seizures/epilepsy: Date of last seizure_____________
43. Y N Thyroid conditions/ medications
44. Y N Liver disease/Hepatitis
45. Y N Stomach problems/gastritis/ ulcers/reflux disease
46. Y N Bowel problems/Colitis/Irritable bowel/Crohns
47. Y N Lung Problems/Disease/Asthma=(circle one) Childhood, Seasonal; Chronic
48. Y N Anemia/Low Iron/Sickle Cell/Thalassemias/Blood diseases/Lupus
49. Y N Gallbladder disease/Surgery
50. Y N Cancer
51. Y N Numbness in legs or arms
52. Y N Are you currently under care for a problem/illness by a health care professional? Explain ____
53. Y N Have you ever been hospitalized (except childbirth):
    Explain ____
    ____
54. Y N Received blood products before 1978
55. Y N Do you faint with needles/finger sticks/pap smears
56. Y N Ever react to ANY DRUG/MEDICATION/FOOD: including (circle): barbiturates, anesthesia, shellfish, eggs, soy, Iodine, metals, latex ____________
57. Y N Have you ever been put to sleep for any surgery? Did you have any problems-Y N
58. Y N Immunizations up to date: Last tetanus: ________
    Rubella vaccination: Y N Hepatitis B: Y N HPV Vaccine: Y N
59. Y N Do you have any piercings in your mouth?
60. Y N Do you use herbs/vitamins/complimentary therapies

Comments - Staff Only

GYN History:

Circle Y for yes or N for no to the following:

61. Y N Have you <u>ever</u> had a pelvic exam/ Pap smear? Date of last exam _____________
62. Y N Breast disease or surgery
63. Y N Breast/nipple discharge/leaking
64. Y N Are you breast feeding/nursing
65. Y N Mammogram
66. Y N Vaginal infections/itching /burning
67. Y N Vaginal pain/bumps/swelling/sores
68. Y N Sexually transmitted infections (circle all that apply):
    Herpes, HPV, Chlamydia, Gonorrhea, Trichomonas, Syphilis,
    HIV, Hepatitis B, Group B Streptococcal Infection
69. Y N Pelvic inflammatory disease (PID) Date______
    Treatment: ____________________________
70. Y N Endometriosis/Uterine fibroids
71. Y N Cysts on ovaries
72. Y N Abnormal Pap (date) ___________
    Treatment: Repeat pap (date) _____________
    Colpo/Cryo/LEEP/Laser
73. Y N Genital circumcision
74. Y N Bleeding and/or pain with sex
75. Y N Did your mother take medications to prevent miscarriage
    when pregnant with you? DES ( ) other ( )

Menstrual History:

76. Age period began ___________
    Are your cycles/periods regular? Yes ( ) No ( ) Sometimes ( )
    # days in each cycle: ________ # days you bleed: _______
    Use pads / tampons / other _______ # used on heaviest day(s) _______
77. Y N Cramps/pain/bloating/depression
78. Y N Do you use medications/herbs/other __________________ for relief
79. Y N Bleed between periods
80. Y N Menopausal/Peri menopausal
81. First day of last period _____/______/_____ Normal ( ) Abnormal ( )

Family History: **Adopted: Y N**

Fill in below: mom, dad, siblings, grandparents, aunts, and uncles

82. Y N Diabetes ____
83. Y N Heart attack before age 50 ___________________________________
84. Y N High Blood Pressure _______________________________________
85. Y N Cancer (breast, ovarian, uterus) ______________________________
86. Y N Osteoporosis ____
87. Y N High cholesterol ____
88. Y N Alcoholism/addictions/mental illness _________________________
89. Y N Problems with General Anesthesia___________________________
90. Y N Birth defects/genetic illness ______________________________

- What else would you like us to know about you? ____
- I affirm that all of the medical information stated above is true and that I have not had anything to eat, drink or gum since__________

Client signature ____ Date: _________________ Updated: ______________________

Counselor signature____ Date: _________________ Updated: ______________________

RN Pre-op Signature____ Date: __________________ Updated: _____________________

MD/NP Review ________________________________ Date:___________ Time:_________ Updated: _____________ Time: __________

APN/CRNA Review___________________________ Date:___________Time:_________ Updated: _____________ Time: ___________

This information is confidential and will not be released without your written permission.