

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.

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

1. Please indicate your race:

- | | |
|--|---|
| <input type="checkbox"/> Asian Pacific Islander | <input type="checkbox"/> Multi-Racial (Other) |
| <input type="checkbox"/> Asian/Asian American | <input type="checkbox"/> Multi-Racial (Person of Color) |
| <input type="checkbox"/> Bi-Racial (Other) | <input type="checkbox"/> Native American |
| <input type="checkbox"/> Bi-Racial (Person of Color) | <input type="checkbox"/> White/Caucasian |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Other/Unknown |
| <input type="checkbox"/> Hispanic/Latino | |

2. Please indicate your primary language:

- | | | | |
|------------------------------------|-----------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Arabic | <input type="checkbox"/> French | <input type="checkbox"/> Mixtec | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Bosnian | <input type="checkbox"/> German | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Cakchikel | <input type="checkbox"/> Hindi | <input type="checkbox"/> Punjabi | <input type="checkbox"/> Zapotec |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Japanese | <input type="checkbox"/> Quiche' | <input type="checkbox"/> Other |
| <input type="checkbox"/> English | <input type="checkbox"/> Korean | <input type="checkbox"/> Russian | |

3. Please indicate your religion:

- | | | |
|---|--|---|
| <input type="checkbox"/> Agnostic | <input type="checkbox"/> Episcopalian | <input type="checkbox"/> Mormon/Latter Day Saints |
| <input type="checkbox"/> Atheist | <input type="checkbox"/> Evangelist/Fundamentalist | <input type="checkbox"/> Muslim |
| <input type="checkbox"/> Baptist | <input type="checkbox"/> Hindu | <input type="checkbox"/> Presbyterian |
| <input type="checkbox"/> Buddhist | <input type="checkbox"/> Jehovah's Witness | <input type="checkbox"/> Quaker |
| <input type="checkbox"/> Catholic | <input type="checkbox"/> Jewish | <input type="checkbox"/> Unitarian |
| <input type="checkbox"/> Christian | <input type="checkbox"/> Lutheran | <input type="checkbox"/> Wiccan |
| <input type="checkbox"/> Church of Christ | <input type="checkbox"/> Methodist | <input type="checkbox"/> Other |

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

- | | | |
|---|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Deaf | <input type="checkbox"/> Mute |
| <input type="checkbox"/> Blind | <input type="checkbox"/> Limited Range of Motion | <input type="checkbox"/> Non-Ambulatory |
| <input type="checkbox"/> Breathing Impaired | <input type="checkbox"/> Multiple Disabilities | <input type="checkbox"/> Other |

5. Please indicate your relationship status:

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Partnered |
| <input type="checkbox"/> Widowed | <input type="checkbox"/> Legally Separated |
| <input type="checkbox"/> Married | <input type="checkbox"/> Single |

6. Please indicate your national origin:

- | | |
|---|---|
| <input type="checkbox"/> African (Any Country) | <input type="checkbox"/> Korean |
| <input type="checkbox"/> American | <input type="checkbox"/> Mexican |
| <input type="checkbox"/> Asian (Country Not Listed) | <input type="checkbox"/> Middle Eastern (Any Country) |
| <input type="checkbox"/> Bosnian | <input type="checkbox"/> Native American |
| <input type="checkbox"/> Brazilian | <input type="checkbox"/> Puerto Rican |
| <input type="checkbox"/> Caribbean (Non-Puerto Rican) | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Columbian | <input type="checkbox"/> Salvadorian |
| <input type="checkbox"/> Guatemalan | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Indian | <input type="checkbox"/> Other |
| <input type="checkbox"/> Japanese | |

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Less than \$12,250 | <input type="checkbox"/> \$29,251 - \$33,500 | <input type="checkbox"/> \$75,001 - \$100,000 |
| <input type="checkbox"/> \$12,251 - \$15,500 | <input type="checkbox"/> \$33,501 - \$37,750 | <input type="checkbox"/> \$100,001 - \$150,000 |
| <input type="checkbox"/> \$15,501 - \$20,750 | <input type="checkbox"/> \$37,751 - \$42,000 | <input type="checkbox"/> \$150,001 - \$200,000 |
| <input type="checkbox"/> \$20,751 - \$25,000 | <input type="checkbox"/> \$42,001 - \$50,000 | <input type="checkbox"/> \$200,001 - \$250,000 |
| <input type="checkbox"/> \$25,001 - \$29,250 | <input type="checkbox"/> \$50,001 - \$75,000 | <input type="checkbox"/> Greater than \$250,000 |

8. Please indicate your sexual orientation:

- | | |
|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> Pansexual |
| <input type="checkbox"/> Gay | <input type="checkbox"/> Queer |
| <input type="checkbox"/> Heterosexual | <input type="checkbox"/> Questioning |
| <input type="checkbox"/> Lesbian | <input type="checkbox"/> Other |

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

- | | | | |
|----------------------------|----------------------------|----------------------------|---------------------------------------|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 4 | <input type="checkbox"/> 7 | <input type="checkbox"/> 10 |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 5 | <input type="checkbox"/> 8 | <input type="checkbox"/> More than 10 |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 6 | <input type="checkbox"/> 9 | |

10. Please indicate your level of education:

- | | |
|--|---|
| <input type="checkbox"/> Currently in Middle/High School | <input type="checkbox"/> Two Year Undergraduate Degree |
| <input type="checkbox"/> Did Not Graduate High School | <input type="checkbox"/> Four Year Undergraduate Degree |
| <input type="checkbox"/> High School Graduate/GED | <input type="checkbox"/> 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
- Community Organization
- Creative Loafing
- Discount Coupon
- Friend
- Gay Yellow Pages
- Health Department
- Health Fair/Table
- In-Site Magazine
- Mental Health Professional

Name: _____

Location: _____

- NAF Hotline

- Physician

Name: _____

Location: _____

- Presentation
- Southern Voice
- Website (FWHC)
- Yellow Pages
- Other Internet Ads/Listing
- Other

Please Specify: _____

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 you smoke? How many cigarettes/day _____
17. Y N Do you drink? How much alcohol do you drink per week _____
18. Y N Do alcohol/drugs cause problems in your life?
19. Y N Have you ever abused alcohol? Yes () No () Drugs? Yes () No ()
20. Y N Emotional/ mental illness? Anti-Depressive, anxiety or psychotic medications
21. Y N Feel you are in an abusive relationship
22. Y N As a child did anyone touch your private body parts or ask you to touch theirs
23. Y N Do you have any piercings in your mouth

Comments - Staff Only

Comments - Staff Only

- 24. Y N Do you feel you need to speak to a counselor of any kind
- 25. Y N Do you use recreational drugs
What kind? _____ Last date of use _____
- 26. Who helps and supports you with your problems _____
- 27. Who do you live with _____

OB History:

Complete below:

- 28. 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: _____

29. Are you Rh neg: Y N Have you received Rhogam: Y N

- 30. Y N Trouble getting pregnant/staying pregnant
- 31. Y N Used fertility treatments/medications
- 32. 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)

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

**Feminist Women's Health Center's
Cliff Valley Clinic
Client Certification form**

Today's Date, __/__/__ Date Appointment made, __/__/__ Time, _____

I, _____, request that an abortion be performed on me today,
Printed name

I certify that:

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 has told me, by telephone, in person, or by automated script,

- 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 chose to:

Not to view the State materials to view the State written materials (viewing these materials will result in another mandatory 24 hour wait)

- 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 certify that I am _____ years of age, date of birth __/__/_____.

I verify that this information is correct and accurate.

Client's Signature _____

Translator Signature _____

Witness Signature _____

Physician Signature _____