



"A women's center serving the families of our community"

HIPPA PRIVACY PRACTICES

SUMMARY OF PATIENT RIGHTS AND RESPONSIBILITIES

- Your medical information is protected. It will be kept confidential and is only used or disclosed for treatment that will ensure your care and wellness.
- We may leave messages for you regarding your medical care or next appointment with us via voice mail or text messaging, unless indicated otherwise.
- We will supply appropriate and necessary information to insurance companies and/or financial companies if needed.
- You have the right to access and obtain copies of your health information records, including amending authorization to whom medical information may be released.
- If you believe your privacy rights have been violated, you may file a complaint. Filing a complaint will not infringe on your patient care or privacy rights. No action will be taken against you for filing a complaint.
- This is a summary of your privacy practices. The full text is available to you today or online at: fallschurchhealthcare.com

I have read this summary of my privacy rights. I understand my rights and responsibilities as well as the privacy practices at the Falls Church Healthcare Center. I understand the full text of FCHC's patients rights are available to me at: fallschurchhealthcare.com or by request at the front desk.

- I would like a copy of the full text of Falls Church Healthcare Center's privacy practices.
- I do not want a copy of the full text of Falls Church Healthcare Center's privacy practices.

X _____
Patient Name (Print)

Date of Birth

X _____
Patient Signature

Todays Date



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Patient Contact Sheet

Patient Name: _____ Date of Birth: _____
 Mobile Phone Number: _____ May we Leave A Message? YES NO
 Home Phone Number: _____
 Valid Email Address: _____
 Home Address: _____

The Falls Church Healthcare Center has the capability to text and email patients regarding past, present and future appointments. The nature of the text messages and emails that are sent may be related to:

- Appointment Reminders
- Office Hour Updates
- Scheduling Reminders
- Billing Matters
- Scheduling Updates
- Request for Feedback

OPT OUT: I do not want FCHC to send me automated reminders about my appointment. I understand that FCHC staff members may still contact me about my appointment(s) without using the automated appointment reminder system. _____
 Patient Initials

Patient Demographic Information

The information in this box is submitted to the Division of Vital records, Virginia Department of Health. No identifying information will be submitted.

County of Residence: Fairfax Arlington Loudoun Prince William Other _____

Highest Grade/Degree Completed: _____

Marital Status: Married Single

Race: Black/African American White/Caucasian Native American or Alaska Native
 Native Hawaiian or other Pacific Islander Asian (Please list county of origin) _____
 Mixed race (please list all) _____

Ethnic Origin: Hispanic Country of Origin _____
 Other County of Origin _____

I agree that the above is correct and accurate. I am aware that the information on this form will remain valid unless I submit an updated form.

X _____
Signature

Todays Date



Medical History

First Name: _____ Last Name: _____ Date: _____
 Birth Date: _____ Age: _____ Phone: _____
 Emergency Contact (Required): _____ Relationship: _____ Phone: _____
 Occupation: _____ Last Menstrual Period: _____

Pregnancy History

Number of Live Births: _____ Abortions: _____ Miscarriages: _____ Stillbirths: _____ Ectopic or Molar: _____ Total: _____
 Problems with pregnancies: _____

Patient's Medical History

YES NO

- Abnormal Pap
- Anemia
- Anesthesia Problems
- Asthma
- Bleeding Disorders
- Body/Facial Piercings
- Breast Lumps
- C-Sections (List Years/Reasons): _____
- Cancer
- Diabetes
- Fibroids

YES NO

- Headaches/Dizziness
- Heart Disease/Heart Attack
- High Blood Pressure
- High Cholesterol
- Kidney/Bladder Problems
- Liver Disease/Hepatitis
- Malignant Hyperthermia
- Migraine Headaches
- Pap Smear _____ (Year)
- PID (Pelvic Inflammatory Disease)
- Psychiatric Problems

YES NO

- Serious Injury (List): _____
- Severe Depression/Anxiety
- Sexually Transmitted Disease(s): _____
- Seizures/Neurological
- Stomach/Bowel Problems
- Stroke, DVT, Pulmonary Embolism
- Surgeries: _____
- Thyroid Problems
- Ovarian Cyst/Tumor
- Vision Problems
- Other Medical Problems: _____

Do you have pain or bleeding with sex? Yes No Are you receiving medical care for any type of medical problem? Yes No
 If other medical conditions explain: _____

Previous anesthesia or medication problems: _____

Allergies (meds, latex, foods): No Known Drug Allergies Yes, list: _____

Are you currently taking any **medications, herbs, diet pills, or vitamins**? _____

Partners are: Men Women Both

Use of alcohol: Never Former Yes, Drinks per week: _____

Use of tobacco: Never Former Yes, Packs per day: _____

Use of drugs: Never Former Yes, Type: _____

(Other than marijuana)

Could you, or someone close to you, benefit from a referral for counseling or other help for any form of sexual or physical violence or verbal/emotional abuse? Yes No

Family Medical History

Has anyone in your immediate family ever had:

- Diabetes Uterine, Ovarian, or Cervical Cancer
- Hypertension, Stroke, Heart Attack

Menstrual History

How old were you when you started your period? _____

Do you have your period every month? Yes No

How many days do you flow? _____

Flow is: Heavy Moderate Light

Birth Control History

What method(s) have you tried? (all that apply):

- Pill Patch Ring Shot IUD Implant Cervical Cap
- Diaphragm Condom Spermicide Fertility Awareness Withdrawal Other: _____

What method are you using now? _____

What problems did you have with these methods? _____

What method would you like to use now? _____

The Privacy Standards established by 2003 HIPPA Provisions addressing the privacy and security of patient data mandates patient consent and authorization prior to release of identifying personal health information. FCHC will continue to honor your trust. Your express written authorization is required for release of any personal information. FCHC will not routinely report identifying information to other health agencies unless you have initialed here. _____

I have provided complete and accurate information about my Medical History. I authorize Falls Church Healthcare Center to use my information for purposes of treatment, payment and health care only.

Patient Signature _____ Date _____ History reviewed _____

HISTORY REVIEWED BY M.D. _____ DATE: _____



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Insurance Carriers Currently Accepted

Updated October 2018

Aetna PPO, HMO	Carefirst Blue Choice, HMO PPO
Anthem HMO, PPO	Cigna
Assurant	Coventry
PHCS	Aetna Signature Administrator
Coresource	Anthem Healthkeeper Plus
Carefirst Administrator	Great West
Guardian	Meritain Health
One Net Alliance	First Health Network

Most insurance companies cover Gynecologic services, contraception, and abortion care but your individual policy obtained by your employer may have restrictions. Let us check for you or you can call your customer service representative listed on your insurance card. Please provide your insurance information when you schedule your appointment so our FCHC staff can verify your benefits for you.

- Policies from Blue Cross Blue Shield with a prefix, "R" (Federal Government Restricted) and Golden Rule do not cover abortion care.
- Medicare, Medicaid, and Tricare do not cover abortion care.
- We do not accept First Health (which only covers injury or illness not related to routine GYN services).