"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: (*Other than marijuana*)	☐ Never	☐ Former	☐ Yes, *Type:* _____

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: _____

Falls Church Healthcare Center (FCHC)
Patients Ultrasound Consent and Certification of Waiting Period
As Required by VA Code 18.2-76 effective July 1, 2012

Patient Printed Name _____ **Date of Birth** _____ **Date** _____

ADVISORY: We at Falls Church Healthcare Center (FCHC) believe you know what is best for your medical care and have always given our patients options to choose their care including viewing your ultrasound if desired. An ultrasound is an image taken of your uterus by abdominal or vaginal wand (transducer) that gives us an estimate of gestational age as well as details of your anatomy. FCHC believes before or during each patient's medical care ultrasounds as part of a comprehensive medical screening, can be useful to your doctor and to you. The Virginia legislature as of July 1,2012 requires you complete the ultrasound step of your abortioncare appointment at least 24 hours before your medical or surgical abortion (or 2 hours before if you live more than 100 miles away from our Center). The Virginia legislature also requires you to formally decline or choose to include options listed below as part of your informed consent. We know this new legislation as well as returning for your appointment on another day (or the additional 2 hours wait) may be an inconvenience for you, and we appreciate your understanding. If you would like to comment on this mandatory requirement to the Virginia Department of Health their complaint policy and contact information is detailed in our privacy policies.

Please check the boxes to indicate your choices then sign the certification: *You will have the opportunity to discuss these options and your care with the nurse or doctor during your ultrasound.*

1) ☐ I decline to **OR** ☐ I choose to view during my examination the image produced by my ultrasound
2) ☐ I decline to **OR** ☐ I choose to receive a printed copy of the image produced by my ultrasound
3) ☐ I decline to **OR** ☐ I choose to hear, if audible, fetal heart tones. ***NOTE:*** If you choose to hear fetal heart tones, since this is not standard medical practice within the community for providing gestational age, the Virginia Department of Public Health (VDH) under this VA Code 18.2-76 D5 and F1 will provide a statewide list of public and private agencies and services qualified to provide ultrasound imaging and auscultation of fetal heart tone services free of charge. If you would like FCHC to help you schedule a fetal heart tone service let us know.
4) ☐ My sonogram was provided at Falls Church Healthcare Center **OR**

   ☐ My sonogram was provided by _____

   at _____ and I have the required copy for my medical record.

   address or contact number

I certify that my ultrasound was completed and that I was offered the opportunity to view the image, receive a copy of the image and hear fetal heart tones. I certify that my abortion appointment is scheduled at least 24 hours after my ultrasound was completed or I qualify for the 2 hour waiting exception.

Certification:_____ **date**_____

Patient Signature

Complete only if you live more than 100 miles from Falls Church Healthcare Center.
Waiting Period Exception Verification: I qualify for the 2 hour waiting period because I live more than 100 miles from Falls Church Healthcare Center as verified on my contact information form.

Certification:_____ **date**_____

Patient Signature

……*below for STAFF use only*……

*DATE:*_____ *Initials:*_____

☐ Patient verbally offered the opportunity to view, receive copy and hear fetal heart tones. ☐ **Copy of Sono requested and given**

☐ Patient's written certification that opportunity was offered completed above

☐ Patient's written verification of waiting period exception.

PRE-OPERATIVE MEDICATION PATIENT ADVISORY

PLEASE READ, INITIAL, AND RETURN TO RECEPTIONIST.

Thank you for choosing Falls Church Healthcare Center for your services. This information tells you about medications you will take at your next appointment. These pre-operative medicines can increase your comfort and safety during your Aspiration D & C abortioncare. ***There is no additional fee for these medications. You will be able to discuss these medications with the nurse today during your ultrasound services.***

About the Pre-medications: MISOPROSTOL gently relaxes your cervix to safely increase your comfort during an aspiration D & C abortion. Some women experience period like cramping and or spotting while waiting; you will be given a sanitary pad. There are no major side-effects of Misoprostol, minor side-effects can include nausea and rarely diarrhea.

TODAY: After laboratory services the nurse will review your medical history to verify if Misoprostol use is appropriate for you. Please advise the nurse of any drug allergies, medical conditions or concerns you may have when you have your sonogram. **You may not be eligible for Misoprostol if you have cardiovascular disease, inflammatory bowel disease or are breastfeeding.** Then your ultrasound will be completed.

AT YOUR NEXT APPOINTMENT: The pre-medications will be given. **If you are uncertain whether you want to proceed with the voluntary interruption of your pregnancy then you should not take these recommended pre-medication because you may not be able to successfully continue this pregnancy once you take the medicines.** You may have some minor cramping and/or mild nausea after you take the medicines. If that occurs please advise the receptionist. I certify I have read and understand the nature and purpose, benefits and risks of the pre-procedure medication Misoprostol. I certify that I have discussed my medical history. I understand I will have another opportunity to ask questions prior to taking the Misoprostol.

Printed Name_____Patient initials_____ Date of Birth_____Today's Date_____

Staff Use Only □ Consult Dr. □ Patient not qualified for pre-medications because:_____
SONO: □ Not Breast Feeding □ No reported/treated cardiovascular disease □ No reported IBD □ HGB WNL □ No complications with other pregnancy or delivery
□ NKDA Allergies: _____ □ Patient cleared for administration of pre-medication

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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).

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