



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

HIPAA 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 country of origin) _____
 Mixed race (please list all) _____
Ethnic Origin: Hispanic Country of Origin _____
 Other Country 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 _____

Occupation _____ Last Menstrual Period _____

Emergency Contact Name _____ Phone _____ Relationship _____

Pregnancy History- Please list the number of each type of pregnancy. If none, indicate 0.

Live Births _____ Abortions _____ Miscarriages _____ Stillbirths _____ Ectopic _____ Molar _____

Total Pregnancies (include current pregnancy) _____

Problems with pregnancies? No Yes (describe): _____

Medical History- Yes or No

YES NO

Allergies (medication/food)

Anemia
 Anesthesia Problems
 Asthma/ Lung Disease
 Bleeding Disorders
 Body/Facial Piercings
 Breast Lumps
 C-Sections (List Years/Reasons)

Cancer
 Currently Breast Feeding
 Depression, Anxiety, Mental Health or Psychiatric Issues

YES NO

Diabetes
 Fibroids
 Headaches/Dizziness/Migraine
 Heart Disease/Heart Attack
 High Blood Pressure
 High Cholesterol
 HIV/AIDS
 Kidney/Bladder Problems
 Liver Disease/Hepatitis
 Malignant Hyperthermia
 Pap Smear _____ (Year)
Results Abnormal/HPV? _____
 Pelvic Infection/PID
 Seizures/Neurological Problems
 Serious Injuries _____

YES NO

Sexually Transmitted Infections

 Stomach/Bowel Problems
 Stroke, DVT, Pulmonary Embolism or Blood Clot
 Surgeries _____

 Thyroid Problems
 Ovarian Cyst/Tumor
 Vision/Eye Problems
 Other Medical Conditions/Problems

Do you have pain or bleeding with sex? Yes No

List all current medications, herbs, diet pills, minerals or vitamins _____

Sexual Partners: Men Women Both

Alcohol Use: Never Yes, Drinks per day: _____ Last Use _____

Tobacco Use: Never Yes, Packs per day: _____ Last Use _____

Recreational Drug Use (except marijuana): Never Yes, Types _____ Last Use _____

Do you experience sexual, physical, emotional or verbal violence/abuse? Yes No

Do you want referrals/help for violence/abuse Yes No

Family Medical History- For Parents and Siblings Only

Diabetes
 Bleeding or Clotting Disorder
 Breast, Cervical, Ovarian or Uterine Cancer
 Hypertension, Stroke, Heart Disease

Menstrual History

What age was your first period? _____
Do you bleed monthly? Yes No
How many days? _____
Flow is: Heavy Moderate Light

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

Pills Patch Ring Shot/Depo IUD Implant
 Cervical Cap Diaphragm Condom Spermicide Fertility Awareness Withdrawal
 Other: _____
Current Method _____
Problems with your birth control? _____
Preferred method? _____

The privacy standards established by 2003 HIPPA Provisions address the privacy and security of patient data.

I have provided complete and accurate information about my Medical History.

FCHC will not routinely report identifying information to other health agencies unless you initial here _____.

I authorize Falls Church Healthcare Center to use my information for purposes of treatment, payment and health care only.

Patient Signature _____ Date _____

History Review by Med. Professional _____ Date _____

History Review by MD _____ Date _____



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Insurance Carriers Currently In-Network with FCHC

Updated May 2019

- We welcome ALL patients with or without insurance.
- Below is the list of Insurance Carriers currently in-network at FCHC. **Please note carriers with * will not include abortioncare services.**
- You can call the center at 703-532-2500. You will be asked to provide your Insurance information to the scheduler when you make your appointment or include your information on your on-line appointment request. As a courtesy we can verify your benefits and financial responsibility prior to your appointment.

Aetna PPO, HMO	Cigna
Aetna Signature Administrator	Coresource
Anthem HMO, PPO, Healthkeepers	Coventry
*Anthem Healthkeepers Plus	*First Health Network
Assurant	Great West
Carefirst Administrator	Guardian
Carefirst Blue Choice, HMO PPO	*Meritain Health
*Carefirst Blue Cross Blue Shield, ID Prefix with: "R"	One Net Alliance
	*PHCS

- Medicare, Medicaid and government insurance plans cover abortioncare only in the case of rape, incest or severe problems with health of pregnant woman.
- First Health Network International Travel Insurance only covers injury or illness not related to routine gynecological services.