"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_____

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.

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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.

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