"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/privacy-policy 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 Alaskan 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 (Food/Medication) _____ _____ _____
☐	☐	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
☐	☐	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_____ _____ _____
☐	☐	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

☐ Pill ☐ 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
Patients Ultrasound Consent and Certification of Waiting Period

VA Code 18.2-76

Name_____ **Date of Birth**_____

The ultrasound:

- Uses soundwaves to produce an image of the uterus
- Can be useful to you and your doctor as part of our comprehensive medical screening
- Helps to provide an estimate of gestational age of your pregnancy
- Helps to determine the location of the pregnancy
- Will be conducted transvaginally (per Virginia Regulation) and/or abdominally

Per Virginia Regulation 18.2-76 Falls Church Healthcare Center is required to ask the following questions.
Indicate your preference below:

Yes	No	
☐	☐	I want to view the ultrasound.
☐	☐	I want to receive a printed copy of the ultrasound.
☐	☐	I want to go to another doctor's office to hear, if audible, fetal heart tones.

Note: Falls Church Healthcare Center (FCHC) follows the community standard for early pregnancy care. FCHC does not provide auscultation (hearing) of fetal heart tones. You may find a statewide list of public and private agencies qualified to provide auscultation of fetal heart tone services at: http://www.vdh.virginia.gov/pregnancy/low-cost-ultrasound-providers/

Additionally, indicate your preference to the following question:

Yes	No	
☐	☐	Do you want to be told if the ultrasound shows multiple pregnancies (Twins, triplets..)

Please indicate which mileage option applies to you. Check only one option:

☐ I live **less than** 100 miles from Falls Church Healthcare Center.
Per Virginia regulation, I understand I am required to delay my abortion care for a minimum of 24 hours after the ultrasound.

☐ I live **more than** 100 miles from Falls Church Healthcare Center**.**
Per Virginia regulation, I qualify for the delay exception**.** I understand I am required to delay my abortion care for a minimum of 2 hours after the ultrasound.

My signature certifies that I provided accurate information on this form. I give my consent for Falls Church Healthcare Center to provide an ultrasound. My signature certifies I was offered the opportunity to view my ultrasound, receive a printed copy of it and indicates if I chose to hear fetal heart tones at a different doctors office.

Signature_____ **Date** _____

----------Official Use Only----------

☐ Patient was verbally offered the opportunity to view her imaging and offered a printed copy.
☐ Copy of ultrasound requested and given
☐ Patient was given the opportunity to receive a list of facilities that provide auscultation of fetal heart tones
☐ Patient provided with a list of private and public facilities that provide auscultation of fetal heart tones
☐ Patients written verification of waiting period exception
☐ Patients ultrasound was provided by FCHC
☐ Patients sonogram was provided by another facility:_____

Staff Initials_____ 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.

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