The Hope Clinic for Women, Ltd.

PATIENT INFORMATION

Last name_____ First name_____

Preferred name/nickname_____

Pronoun(s) □ she/her □ he/him □they/them □ other: _____ Sex: □ male □female

Date of birth_____ Social Security Number _____

Address_____

City_____ State_____ Zip_____

County_____

Email_____

Phone (best contact number)_____ Alternate number_____

Do you prefer caller identification to be BLOCKED/RESTRICTED when contacting you? □ NO □ YES

Race_____ Hispanic: □ YES □ NO

Marital status_____ Occupation_____

Number years of education_____

IN CASE OF EMERGENCY CONTACT

Name _____ Relationship _____

Best contact number _____ Alternate number_____

Hope Clinic for Women, Ltd.

Request for Medical Services and Receipt of Notice of Privacy Practices

Before you give your consent, be sure you understand the information given below. If you have any questions, we can talk to you about them. You may ask for a copy of this form.

Please initial the following:

_____ **Medical Services** I have/will be given information about any test(s), treatment(s), procedure(s), contraceptive method(s), to be provided, including the benefits, risks, possible problems/complications and alternate choices. I understand that I can ask questions about anything I do not understand. I understand that a healthcare provider is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Hope Clinic for Women. At this time, I hereby request that a person authorized by Hope Clinic for Women provide appropriate evaluation, testing, and treatment.

_____ **Notice of Privacy Practices:** I understand that confidentiality will be maintained as described in Hope Clinic for Women's *Notice of Privacy Practices*. I have been given the opportunity to review the *Notice or Privacy Practices* and may receive a written or electronic copy by request. I consent to the use and disclosure of my health information as described in *Notice of Privacy Practices.*

_____ **Referrals:** I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I have been/will be told how to get care in case of an emergency.

_____ **Interpreter Services:** I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visit. I understand that free interpretive services are usually available by phone.

_____**Teaching:** Hope Clinic for Women is a teaching institution. Persons in training, under strict supervision, may be involved in some aspects of my care.

_____ **Reporting:** I understand that certain information or test results may be reported to state agencies (health or social services) if required by law.

Hope Clinic for Women, Ltd.

FINANCIAL POLICY

Hope Clinic for Women wants to provide high quality medical care at an affordable price. In order to offer affordable services, we depend upon our patients to make prompt payment for their services and supplies. Please read these policies carefully and initial as indicated.

_____Methods of Payment: Full payment is expected at the time of service. We accept cash and credit card as payment.

_____Outside funding sources may be applied as a deduction to the total payment due. In some cases written information about this funding or other documents will be required to apply these deductions.

_____ Fees are calculated by services rendered. I understand that my total fee may differ from the initial estimated fee secondary to information obtained during my appointment, the actual services rendered and/or additional services being requested.

_____We reserve the right to refuse to accept credit cards when the patient is not named on the card as an authorized user. We reserve the right to verify ownership of the card. Hope Clinic for Women follows all laws pertaining to HIPAA. However, confidentiality cannot be guaranteed when payment is made by credit card. We reserve the right to disclose confidential information to obtain payment when credit card charges are disputed by the credit card holder or the credit card company.

CONSENT

I hereby consent to receiving the services described in this document, and acknowledge receipt of health information from Hope Clinic for Women as described in this document.

_____ _____

Signature **Date**

WITNESS

I witness the fact that the patient received the above information and had the opportunity to ask questions.

_____ _____

Signature **Date**

Insurance Information, Billing Policy and Financial Responsibility

Hope Clinic for Women participates with various health insurance plans as well as Illinois Medicaid. All patients participating with a health plan are expected to understand their health plan's covered benefits; what services are covered, and what services are not covered, by their plan. It is also the patient's responsibility to understand any financial or cost sharing requirements of their plan, including co-payments or deductibles.

All patients are expected to make payment at the time of service, as determined by their health plan coverage. A sliding fee schedule may be extended to eligible patients for services that may not be covered by a health plan, or patients without any coverage.

Additional costs may occur depending on test results and follow-up services.

INSTRUCTIONS: The following Agreements authorize Hope Clinic to provide services in compliance with this Billing Policy and health insurance company, state, federal, and Medicaid rules.

Initial next to the Agreement that applies to you and sign at the bottom. Note that both patients and staff are requested to sign below.

_____ **RELEASE OF BENEFITS AGREEMENT** I authorize my provider or insurance company to release any information required for this claim and direct my insurance benefits to be paid directly to Hope Clinic for Women. **("OK to bill my insurance")**

(_____ **BENEFIT WAIVER AGREEMENT** I waive coverage, benefits, or reimbursement provided by my health insurance plan. I understand that I will be fully responsible for payment of services provided, and that payment is expected at the time of service. ("Do not bill my insurance"))

I am financially responsible for any balance due. I understand that an insurance billing could result in information regarding my care at Hope Clinic for Women being sent to my parent, guardian, or partner —whomever is the holder of the insurance policy.

This policy has been explained to me and I fully understand my Patient Rights and Responsibilities, as well as the Billing Policy.

NOTE: This form will be completed at the initial visit AND at any time there is a change to insurance coverage.

Patient Signature _____

Date_____

Staff Member Signature _____

Date_____

Hope Clinic for Women, Ltd.

ELECTRONIC COMMUNICATIONS

Please read the consent on Electronic Communications and sign below:
I permit Hope Clinic for Women to send emails or text messages in the following manner and for the following, but not limited to, purposes:

- Send me appointment reminders
- Tell me to go to its website for forms or information
- Send me a request to participate in patient surveys pertaining to the quality of my experience as a patient
- Ask me to phone the office
- Inform me of a change in hours or services

Sensitive information, including lab results, referrals or diagnoses will not be sent via text or email (unless secure). Standard text messaging rates may apply.
I will NOT sign this portion of the consent if people I don't want to share my medical information with can access my email or text.

I acknowledge and accept that the agreed upon emails and text messages from Hope Clinic for Women may be read by everyone who gets or has access to them. They will know that the messages are from Hope Clinic for Women, and they will be able to view their content.

I may cancel this permission form at any time by notifying Hope Clinic for Women in writing. It will be effective on the date Hope Clinic for Women is notified of my cancellation. No further emails or text messages will be sent to me by Hope Clinic for Women after the date this permission is cancelled. If I have scheduled online and already entered my phone number and email address into the online scheduling system used by Hope Clinic, I understand it is my responsibility to request this information be updated or removed if I no longer wish to receive communications relevant to my appointment(s) at Hope Clinic.

My healthcare and payment for my healthcare will not be affected if I do not sign this permission form.
I agree to release and hold harmless Hope Clinic for Women from any liability that may result from using the methods of communication I have given consent to in this permission form. This includes, but is not limited to, breaches of confidentiality or privacy that may come from using those methods of communication (except as required by law).

The email and phone number that I provided on the Demographics information sheet completed today or that I entered into the online scheduling system will be used for electronic communications.

Please sign one of the following:

I have read and agree to the scope of permitted use of email and text messages.

_____ _____
Signature **Date**

OR

I have read and DO NOT AGREE to the scope of permitted use of email and text messages.

_____ _____
Signature **Date**

☐ *Electronic Communications Consent Reviewed._____ (staff initials)*

The Hope Clinic for Women, Ltd.

Ultrasound Consent

I think I am (*will be)* _____weeks pregnant today *(day of the appointment).*

The first day of my last normal menstrual period was _____.

I, (print your name) _____ give my permission for the Hope Clinic's medical staff to perform a limited pelvic ultrasound. The ultrasound will include an abdominal and/or vaginal component.

Ultrasound - general information/abdominal: Ultrasound (or sonography) is a test that uses high-frequency sound waves to show what is inside your body. You will lie on a cushioned table and gel will be applied to your skin; the gel acts as a conductor. A transducer, a hand-held device that sends and receives ultrasound signals, is moved over the area of your body (lower abdomen) being imaged. Images instantly are seen on a television-like monitor and sent to film to be reviewed and interpreted.

Ultrasound - vaginal: A vaginal exam may be used, as needed by the technician, to improve visualization of the pregnancy, uterus or ovaries. The technician will insert a transducer that's about the width of a thumb into your vagina. (Or you may choose to insert this yourself.) The transducer is covered by what looks like a small latex condom. The technician may move the transducer slightly to get a clearer image.

I understand that at the Hope Clinic, the ultrasound is routinely used for the following purposes: to find out the size/length of the pregnancy, to assist in physician guidance during a procedure, or to evaluate for completion of the abortion post-procedure. Other diagnostic information is not routinely obtained; for example, in most cases, this ultrasound cannot detect a tubal or ectopic pregnancy.

_____ _____

Signature of Patient Date

CONFIDENTIAL MEDICAL HISTORY

A. MEDICAL

1. Number of: Vaginal births ___ Living children ___ Still-births ___ C-sections ___ Molar pregnancies ____ Miscarriages___
   Past abortions___ Tubal pregnancies**____ Total pregnancies <u>including this one:</u> (___)**
2. Please explain any complications you have had with childbirth or surgery/abortions (heavy bleeding, etc)
   _____
3. Are you currently on ANY drug or medication, prescribed or non-prescribed? ☐ Yes ☐ No
   Please list all: _____
4. Are you allergic to any medications, latex or anything else? ☐ Yes ☐ No List allergies:
   _____
5. Are you currently breastfeeding? ☐ Yes ☐ No
6. Do you use tobacco (cigarettes, pipes, chewing, etc.)? ☐ Yes ☐ No How much? _____
7. What is your most current HEIGHT: _____ WEIGHT: _____
8. Have you ever had:

☐ Yes ☐ No Heart/cardiac problems _____
☐ Yes ☐ No Diabetes. If yes, list medication(s):_____
☐ Yes ☐ No High blood pressure. If yes, are you on medication? ☐ Yes ☐ No
☐ Yes ☐ No Active gallbladder disease. If yes, has your gallbladder been removed? ☐ Yes ☐ No
☐ Yes ☐ No Migraine headaches diagnosed by a doctor
If yes, do you have vision changes (aura) with your migraines: ☐ Yes ☐ No
☐ Yes ☐ No Blood clot in the brain, heart, legs or lungs (thromboembolism) When? _____
☐ Yes ☐ No Convulsions/epilepsy/seizure. If yes, are you on medication? <u>☐ Yes ☐ No</u>
☐ Yes ☐ No Liver disease (hepatitis, tumors, or damage to the liver)
☐ Yes ☐ No Breast or uterine cancer
☐ Yes ☐ No Blood that doesn't clot properly (such as hemophilia)
☐ Yes ☐ No Blood transfusion? If yes, why?_____
☐ Yes ☐ No Sickle cell anemia
☐ Yes ☐ No Abdominal Surgery If so, what type _____ when_____
☐ Yes ☐ No Kidney disease. If yes, are you on dialysis or renal restricted diet? ☐ Yes ☐ No
☐ Yes ☐ No Asthma What medication/inhaler do you use?_____
If yes, do you have your inhaler with you today? ☐ Yes ☐ No
☐ Yes ☐ No An allergic reaction to any anesthesia, including Novocaine or lidocaine
☐ Yes ☐ No Surgery on your cervix (cone biopsy, LEEP, cryo-surgery (freezing), laser surgery, etc.)
☐ Yes ☐ No Fibroids in the uterus. If yes, size & placement in the uterus: _____
☐ Yes ☐ No An abnormal pap smear or pelvic exam. When?_____
☐ Yes ☐ No A diagnosed vaginal infection or sexually transmitted disease?
What?/When?_____
☐ Yes ☐ No Diagnosis of HIV or AIDS If yes, medications: _____
☐ Yes ☐ No I.V. drug use (cocaine, heroin, etc.)
☐ Yes ☐ No History of depression, anxiety, panic, or bipolar disorder (please circle any that apply)
when diagnosed? _____ treatment?_____
☐ Yes ☐ No Borderline personality disorder? If yes, when diagnosed?_____
☐ Yes ☐ No A.D.D. or A.D.H.D. (Attention Deficit Disorder) If yes, when diagnosed?_____
☐ Yes ☐ No Bulimia, anorexia or other eating disorder?
☐ Yes ☐ No Anything else we should know:_____
_____

9. Please answer yes or no to all of the questions below.
   - ☐ Yes ☐ No Do you have a blood disorder known as Thalassemia?
   - ☐ Yes ☐ No Do you have any active bowel disease? (colitis, irritable bowel syndrome, etc.)
     If yes, details:_____
   - ☐ Yes ☐ No Do you have any immune deficiency disorder (HIV, AIDS, Leukemia, etc.)?
     If yes, details:_____
   - ☐ Yes ☐ No Do you have an alcohol or drug addiction *that is not being managed effectively?*
   - ☐ Yes ☐ No Do you take any of the following drugs **on an everyday basis**? If yes, which one/s?
     ☐ aspirin, ☐ coumadin, ☐ ibuprofen (Advil), ☐ drink alcohol

10. Because street drugs can interact with medications used during the abortion procedure, and can cause patient's breathing to stop and result in death, please answer the following honestly:
    - ☐ Yes ☐ No Have you used Meth (methamphetamine) in the past 3 days? (72 hours)
    - ☐ Yes ☐ No Have ever used any street drug(s)? If yes, when did you last use? _____
      What drug(s)? _____

B. ADDITIONAL INFORMATION:

1. Was this pregnancy a result of rape or forced intercourse? ☐ Yes ☐ No
2. Have you had any testing that diagnosed a fetal abnormality? ☐ Yes ☐ No
   If yes, what is the diagnosis?_____
3. Have you ever been counseled by a psychiatrist, psychologist, or therapist? ☐ Yes ☐ No
   If yes, approximately what year?_____ Brief description of circumstances: _____
   _____

Signature of Patient: X_____Date:_____

Hope Clinic for Women: Driver Form

(to be completed by the driver designated for this patient)

Driver Name_____

Phone Number (best contact number today)_____

Patient's Name_____

Vehicle Type_____

Additional Contact number (not current driver)_____
(This number will be utilized if the driver does NOT pick up the patient within 30 minutes)

Hope Clinic for Women has a strict driver policy to ensure that patients have a safe method of transportation at the time of discharge from our facility. If the driver policy cannot be followed, the patient may have to reschedule their appointment.
I understand that I have been designated as the above patient's driver. I understand that I may leave the property, but must return to pick up the patient **within 30 minutes of the "pick up phone call." I, therefore, agree to stay within 30 minutes of The Hope Clinic.**

_____ _____
Driver Signature Date

Payment/Credit Card Authorization

This section is used if the driver is planning on leaving their credit card with the patient and will not be in the building during payment process.

If you are assisting the patient with payment today and are using cash, please **discuss that with the patient before you leave.**
If you are assisting the patient with payment today and are using a credit card (leave the credit card with the patient) please fill out the information below:
I,_____, give_____ permission to use my credit card in the amount of $_____ at The Hope Clinic for Women Ltd.

If you are unaware of the price the staff with fill the information out during the payment process.

Recovery Room:
Driver Called : Yes No Time_____ Initials_____