

**PLANNED PARENTHOOD OF SOUTHEASTERN VIRGINIA**

403 Yale Drive, Hampton, VA 23666 (757)826-2079  
515 Newtown Road, Virginia Beach, VA 23462 (757)499-PLAN

PLEASE PRINT LEGIBLY		<b>Patient Information</b>		
Last Name:		First Name:		Middle Initial:
Address:		Apt #:	City:	State: Zip Code:
Email address:			Employer:	
Home Phone #:		Cell Phone #:		Work Phone #:
Emergency Contact Name:		Phone #:		Relationship:
<p><b>We are committed to maintaining your confidentiality. At times it's necessary for us to contact you, usually with the results of an abnormal test, through phone calls, email, text &amp;/ or mail (plain white envelope).</b></p> <p align="right"><small>Which method do you wish to EXCLUDE?</small></p> <p><b>If we MAY NOT use one or more of these forms of contact- please check here</b> <input type="checkbox"/></p> <p>Please provide a password to receive test results over the phone: _____</p>				
Date of Birth:		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male		Do you want to receive Planned Parenthood promotions and updates? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Do you have a living will? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<p>How did you hear about us? <input type="checkbox"/> Doctor <input type="checkbox"/> Online search</p> <p><input type="checkbox"/> Ad (please circle where you saw the ad): <input type="checkbox"/> Family <input type="checkbox"/> Facebook</p> <p style="padding-left: 20px;">billboard phonebook TV Radio <input type="checkbox"/> Friends <input type="checkbox"/> Other Planned Parenthood</p> <p><input type="checkbox"/> Community Event/Organization <input type="checkbox"/> School Nurse/Teacher <input type="checkbox"/> Newspaper/Magazine or other Print Ad</p>				
Monthly Income: \$		Family Size supported by income:		
<p>Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Multiracial <input type="checkbox"/> Hispanic: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="padding-left: 20px;"><input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other</p>				
Current form of birth control?		<input type="checkbox"/> Condoms <input type="checkbox"/> Implanon <input type="checkbox"/> Pill <input type="checkbox"/> Diaphragm <input type="checkbox"/> IUD <input type="checkbox"/> Patch <input type="checkbox"/> The Shot/Depo <input type="checkbox"/> NFP <input type="checkbox"/> Other <input type="checkbox"/> Nuvaring <input type="checkbox"/> Sterilization		
Highest level of education completed: <input type="checkbox"/> Middle School <input type="checkbox"/> High School <input type="checkbox"/> Some college <input type="checkbox"/> Bachelor/Masters/PhD				
<p><b>Insurance Information</b></p> <p align="center"><small>(Insurance card and photo ID <u>must</u> be presented at each office visit)</small></p> <p><b>If your insurance does not cover certain tests, procedures or visits you will be responsible for the unpaid balance.</b></p>				
Insurance Company Name:			Policy Number:	
Subscribers Name:			Relationship to Patient:	
Subscriber's Date of Birth:			Please note that some insurance companies send an <b>Explanation of Benefits to the Primary Subscriber's Address</b>	

If possible exposure to HIV from a person during a needle stick or any other procedure means that deemed consent applies; which states that a person's blood will automatically be tested for the HIV antibody and the individual's permission isn't needed. In addition, the same applies to be true if the patient is exposed to an employee's blood during any procedure. (1994 S.B. 395)

I request that payment of authorized insurance benefits be made on my behalf of PPSEV, for any services rendered to me. I authorize the release of medical information about me to my insurance company which is necessary to determine benefits or the benefits payable for related services. I also authorize the release of information to any hospital or physician I may be referred to by this office. I also authorize the release of information for litigation purposes.

- I understand payment is due at the time of service and agree to be responsible for the full amount.
- If my insurance provider does not cover my services, I will personally pay the full amount due.
- If I fail to meet my financial obligations, I agree to pay any collection fee, attorney fee or court costs required to collect my unpaid balance.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

**REQUEST FOR THE PROVISION OF MEDICAL SERVICES**  
**And Acknowledgement of**  
**RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES**

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ **(PLEASE PRINT)**

NAME OF PATIENT: \_\_\_\_\_

SOC. SECURITY # \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mo/day/yr)

TELEPHONE#: \_\_\_\_\_

OR  
LABEL

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

- 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 visits. I understand that free interpretive services may not be immediately available and Planned Parenthood may need to refer me to another health care facility to provide the services necessary for my care.
- I have been given information about the 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 should ask questions about anything I do not understand. I understand a clinician 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 Planned Parenthood.
- I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law. (i.e., HIV, Gonorrhea, Chlamydia, syphilis, etc.).
- Please note that Planned Parenthood of Southeastern Virginia is a teaching institution, and that persons in training, under strict Supervision, may be involved in some aspects of your care.
- I will be given referrals for further diagnosis or treatment if necessary. I understand that if a referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case if an emergency.
- I understand that confidentiality will be maintained as described in Planned Parenthood of Southeastern Virginia's *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.
- I hereby request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).
- I hereby request that Planned Parenthood of Southeastern Virginia be designated as my agent to receive any prescriptions (for a birth control drug or device, if I request it), ordered through Planned Parenthood on my behalf by their nurse practitioner or physician. I understand that these prescriptions have been filled off site and are being delivered to Planned Parenthood to dispense to me. This waiver is good as long as I remain a patient of Planned Parenthood's or until rescinded by me in writing.

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Check here if patient's Guardian or relative is legally required to sign below.**

**Relationship to patient:** \_\_\_\_\_

**Signature of any other person consenting:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I witness the fact that the patient (or person consenting on her behalf) received the above-mentioned information and said she/he read and understood same and had the opportunity to ask questions.

**Signature of Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_