

PLANNED PARENTHOOD® OF SOUTHEASTERN VIRGINIA

403 Yale Drive, Hampton, VA 23666 (757)826-2079
515 Newtown Road, Virginia Beach, VA 23462 (757)499-7526

Urine Pregnancy Test

PLEASE PRINT LEGIBLY

Last Name:		First Name:		Middle Initial:
Address:		City:	State:	Zip Code:
Apt #:	Email address:			
Home Phone #:	Cell Phone #:	Work Phone #:		
Emergency Contact Name:			Phone Number:	

We are committed to maintaining your confidentiality. At times it is necessary for us to contact you, usually with the results of an abnormal test.

Social Security Number:	Date of Birth:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male		
How did you hear about us? <input type="checkbox"/> Ad (please circle where you saw the ad): billboard phonebook TV Radio <input type="checkbox"/> Community Event/Organization			<input type="checkbox"/> Doctor <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> School Nurse/Teacher	<input type="checkbox"/> Online search <input type="checkbox"/> Other Planned Parenthood <input type="checkbox"/> Newspaper/Magazine Which one? _____ <input type="checkbox"/> Other(describe): _____

Do you want to receive Planned Parenthood promotions and updates? Yes No

Monthly Income: \$	Family Size supported by income:
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Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American	<input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Multiracial <input type="checkbox"/> Other
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Hispanic: Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have a living will? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Medical Screening (completed by client)

1st day of last menstrual period: _____ Was it normal? Yes No If no, explain: _____

Currently using birth control? Yes No If yes, method: _____ How long: _____

History of: Abnormal Bleeding Ectopic Pregnancy Missed or Spontaneous abortion Pelvic Infection

Reason for Test: Planned Pregnancy Contraceptive Failure No Regular Birth Control

Test Results you hope to see: Negative Positive Doesn't matter

Signs/ Symptoms: _____

Possible Problems: Spotting/Bleeding Fever Abdominal Pain Vomiting Other: _____

Assessment (completed by clinic staff)

Gravida:____ Para:____ Live Births:____ Spontaneous abortion:____ Elective abortion:____ Living children:____

Urine high-sensitivity HCG Pregnancy Test Result: Negative Positive (EDC:____ EDD:____) Indefinite

Client Education: Contraceptives **ESSURE** STDs Prenatal Care Adoption Abortion Service

CIIcs given: Pregnancy Tests EC HOPE Nuvaring COCs Medroxyprogesterone IUS

If Minor: Encouraged Parental Involvement

Intake Staff Signature: _____	Date: _____
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Licensed Qualified Health Care Provider _____	Date _____
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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 of 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.

- **I understand I have the right to request a chaperone to be present for any physical examinations.**
- **I hereby acknowledge receipt of Planned Parenthood's notice of health information privacy practices.**
- **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: _____ 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: _____