GILLETTE REPRODUCTIVE HEALTH
APPLICATION OF SERVICES

Name:_____ Email:_____

Mailing Address:_____City:_____State:_____ Zip _____

Physical Address:_____ City: _____ State:_____ Zip _____

Home Phone:_____ Work Phone:_____ Cell Phone: _____

Date of Birth:_____ Age:_____ Sex:_____ Years of school completed:_____

Marital Status: _____Single _____Married _____Divorced _____Living together _____Other _____

Person to contact in an Emergency:_____ Phone _____

Relationship to you_____

List names and ages of members in your household:

Name _____ Age ____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Name _____ Age ____ Name _____ Age _____

Place of employment for yourself and each adult household member:

Patient _____ Adult #2 _____

Adult #1_____ Adult #3 _____

Gross monthly income for all family members living at home: (Please provide the following information)

Patient	Adult 1	Adult 2	
$_____	$_____	$_____	Employment (check stub from employer(s) or tax return)
$_____	$_____	$_____	Social Security (award letter)
$_____	$_____	$_____	Disability (award letter)
$_____	$_____	$_____	Public Assistance (AFDC) (check stub)
$_____	$_____	$_____	SSI (Medicaid coupon)
$_____	$_____	$_____	Child Support (divorce decree or bank statement)
$_____	$_____	$_____	Food Stamps (printout of card or copy of credit card)
$_____	$_____	$_____	Unemployment (unemployment check stub)
$_____	$_____	$_____	Disability (Award Letter)

I certify that I have examined the above information and to the best of my knowledge it is true and correct. I understand that I may be asked to provide verification of the above information.

Client Signature:_____ Date:_____

Staff Signature:_____ Date:_____

FOR OFFICE USE ONLY

Sliding Fee Scale: 1 2 3 4 5

CSBG Eligible: Y N

Appropriate financial copies received: Y N N/A **02/14**

For Financial purposes my chart might be reviewed by a CSBG representative_____

My initials indicate my approval

GILLETTE REPRODUCTIVE HEALTH

Consent for Services

The need for an annual gynecological examination by a qualified health care professional has been explained to me. I have been given the opportunity to ask questions about my health care and to have them answered.

I also understand that follow-up examinations or additional testing may be required based upon the findings of my physical examination. I understand that it is my responsibility to follow through with these requirements. I understand that I must have all additional testing. The need for this testing will be explained to me, and I may ask any questions regarding these findings as they arise.

Further, I realize that if tests are taken for Sexually Transmitted Diseases (STD's)/HIV, reporting of positive results to the state public health agency is required by law.

I understand that every attempt will be made to maintain the strictest confidentiality regarding my reproductive health care, but in specific circumstances, it may be necessary to temporarily suspend that confidentiality. These instances may include, but not be limited to the following:

1. Court Order
2. Child abuse/ neglect cases
3. STD cases
4. Abnormal laboratory results or medical findings that may jeopardize my health

I understand that every attempt will be made to contact me regarding my health care. I also understand that it is my responsibility to provide the clinic with an address and telephone number where I can be reached, and to update this information as necessary. If I do not wish to be contacted at home, I will provide an alternate address and phone number where I can be reached. I hereby request that a provider authorized by GILLETTE REPRODUCTIVE HEALTH examine and/or treat me as necessary.

Client Signature_____ Date_____

Staff Signature _____ Date_____

FOR MINORS ONLY

It is the federal policy of federal funding sources that all clients under the age of 18 be encouraged to involve their parents/guardians concerning their sexual activity and reproductive health care. I have been encouraged by the staff to involve my parents concerning my medical care at this facility. Your signature on the bottom of this form does not mean your parents /guardians will be informed of your visits to this clinic.

I have also received counseling and information on how to resist attempts to engage in sexual activity.

Client Signature_____Date_____

Staff Signature_____Date_____

HIPAA NOTICE OF PRIVACY PRACTICES

GILLETTE REPRODUCTIVE HEALTH
1304 W. 4th Street
GILLETTE, WY 82718
307-682-8110

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your (PHI) may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your (PHI), to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose (PHI), as necessary, to a health care agency that provides care to you. For example, your (PHI) may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: (PHI) will be used, as needed, to obtain payment for your health care services. In example, filing to health care insurances.

Healthcare Operations: We may use or disclose, as needed, your (PHI), in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conduction or arranging for other business activities. For example, we may disclose your (PHI), to medical school students that see patients at our office. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your (PHI), as needed, to contact you to remind you of your appointment.

We may use or disclose your (PHI), in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

(continued on back of form)

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your Protected Health Information (PHI).

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to (PHI).

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your (PHI) for the purposes of treatment, payment or healthcare operations. You may also request that any part of your (PHI) not be disclosed to family members or friend who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your (PHI), your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your Protected Health Information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to (PHI). If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature:_____ Date_____

Gillette Reproductive Health
Health History Form

NAME:	Date of Birth:	Age:	Today's Date:

Personal Health History:

Who do you see for health care? _____
List your <u>DRUG</u> allergies:
List other allergies (Food/Seasonal):
Immunizations you have had? Tetanus (WHEN) _____Measles (Rubella) ____ Varicella (Chicken Pox)_____ HPV (Gardasil) _____ _____ _____ Meningococcal _____ Hepatitis B _____ Annual Flu _____
Ever been in the hospital for illness or an operation?
How often do you go to the Dentist? | Last Dentist appointment _____
List all medications, vitamins, and supplements you take:

Ever had or currently have:	**NOW**	**Never**	**Past**	
Anemia (iron poor blood)?				
Asthma, Tuberculosis or other lung diseases?				
Blood clots?				
Breast problems?				Date of last MAMMOGRAM?
Cancer of any type?				
Depression?				
Diabetes?				
Hepatitis (liver disease)				
High blood pressure?				
Seizure or epilepsy?				
Thyroid problems?				
Urine or kidney infection?				
Headaches? (tension or stress)				
Migraine headaches?				
Do you like your present weight?				
Any history of anorexia or bulimia?				
Do you exercise regularly?				
Illegal (street) drugs?				
Ever used IV or needles to take drugs?				
Ever had a blood transfusion?				
Are you having sex with someone?				
How long with your current partner?				
How many partners in your lifetime?				
Has anyone ever forced you to have sex?				
Has a partner ever threatened, bullied, or physically hurt you? (slap, hit, kick, scream)				
Do you or your partner have sex with others?				
Any pain or bleeding with sex?				
Ever been <u>tested or treated</u> for an STD?				Which one?

Gillette Reproductive Health
Health History Form

Contraceptive History:
Circle all BIRTH CONTROL methods you have used? **Plan B –** Depo Provera – **Pills –** Diaphragm – **Sponge** – Ring – **IUD** - Pulling Out – **Rhythm** – Condoms – **Spermicidal Foam** – Natural – **Sterilization** – Patch – **Implant -** None Your CURRENT birth control method is? _____ Are you interested in discussing other BC methods? _____

Pregnancy Information:	YES	NO	Comment/Explain
Have you ever been pregnant?			
Do you want to be pregnant within the next year?			
Ever had a C-Section delivery?			

How many and date of each pregnancy:	**Date(s)**	
Delivered full term? _____ Premature or low birth weight?_____ AB/Miscarriage/Still Birth?_____ How many living children do you have?_____		

Menstrual Information:				
How old when your first period started?		Do you bleed between your periods?	YES	NO
How often do you get your period?		Do you douche?	YES	NO
How many days do your periods last?		Do you do a self –breast exam?	YES	NO
Comments:		Do pain/cramps or other period problems bother you?	YES	NO

Family Health History (Mother, Father, Sister, Brother):

	YES	**NO**	**Unsure**	
Are you an adopted child?				
Birth defects or genetic disorder?				
Cancer?				
DES use (Your MOM or YOU?)				
Diabetes or high sugars?				
High blood pressure? Heart disease?				
Clotting disorder? Stroke?				

This information is true and complete to the best of my knowledge.

_____Patient Signature

Staff Signature _____ DATE: _____

06.04.14

GILLETTE REPRODUCTIVE HEALTH
PATIENTS BILL OF RIGHTS AND RESPONSIBILITIES

You have the rights to:

- Be provided services without regard to race, color, national origin, religion, age, sex, parity, or marital status.
- Confidential treatment of records and disclosures, and be afforded the opportunity to approve or refuse their release to any individual except as required by law or third party payment contract.
- Be informed of the services available.
- Be informed of the clinic policies and charges for services, including eligibility for third party reimbursements.
- Be treated with dignity, respect, and privacy in treatment and care for personal need.
- Be informed of provisions for off-hour and emergency coverage.
- Be informed of medical conditions and treatment plans.
- A clear and concise explanation in lay-persons terms of all proposed procedures. Probable risks and benefits, and serious side effects.
- Be provided education and counseling.
- An informed consent or refusal to any particular drug, test procedure, or treatment.
- Voice grievances and recommend changes in policies and services to clinic staff and the governing board.
- Know the names of the clinic staff.
- Be provided an interpreter if you do not speak English.

It is your responsibility to:

- Keep appointments and notify the clinic in advance when you can't keep them.
- Give truthful information.
- Abide by the rules and regulations governing patient conduct and responsibility.
- Be aware of the possible side effects of your method of birth control and respond appropriately if you suspect a serious side effect.
- Understand your chosen method of contraception and use it responsibly.
- No one is denied services based upon ability to pay. However, you agree to pay what you honestly can of your fees.

ALL PATIENT RELATED ACTIVITIES OF FAMILY PLANNING SERVICES MUST BE CONDUCTED WITH AN OVERRIDING CONCERN FOR THE PATIENT, AND ABOVE ALL, THE RECOGNITION OF HIS/HER DIGNITY AS A HUMAN BEING SUCCESS IN ACHIEVING THES RECOGNITION ASSURES SUCCES IN DEFENSE OF THE RIGHTS OF THE PATIENT.

Print Name:_____

Client Signature:_____Date:_____

GILLETTE REPRODUCTIVE HEALTH
1304 W. 4th Street; PO Box 2915, Gillette, WY 82717
(307) 682-8110 fax (307) 685-1193

If Plan A fails go to Plan B.

EMERGENCY CONTRACEPTION PILLS INSTRUCTIONS AND CONSENT FORM

1. Take the first pill in the package as soon as possible with food. Take the next pill as close to **12 hours later** as possible, also with food.

2. Emergency contraception pills (ECP) is a oral contraceptive that should be taken 72 hours after unprotected intercourse. GRH uses Plan B, a progestin only emergency contraception which is 85 –90% effective. The Plan B emergency contraception inhibits or delays ovulation to prevent fertilization; may alter endometrium to impair implantation; may alter transport of sperm. It **WILL NOT** cause an abortion and there is no evidence to link this use of hormones with fetal abnormalities.

3. ECP's MAY CAUSE some side effects. The most common of these are breast tenderness, headache, and mild nausea. Taking both doses with plenty of water and a little food can help prevent nausea.

4. Your next period may start a few days earlier or later than expected and your menstrual flow may be heavier or lighter than usual. However, you SHOULD begin menstruating within three weeks of taking the ECP. If you do not, you must return to the clinic for a pregnancy test.

5. Due to the fact that the ECP is LESS effective than other methods of birth control, GRH staff recommend that you begin using a regular method as soon as possible. Our staff will be happy to give you information about all methods available through our clinic. We can also counsel you about preventing sexually transmitted infections.

I am voluntarily receiving emergency contraceptive pills (ECP). I am aware that they ARE NOT 100% effective in preventing pregnancy. Information about ECP and how to use them has been provided to me and I have been given the opportunity to ask questions.

_____
Print Name

_____ _____
CLIENT'S SIGNATURE DATE

_____ _____
WITNESS SIGNATURE DATE

GILLETTE REPRODUCTIVE HEALTH
CONSENT FORM FOR ORAL CONTRACEPTIVES (COMBINED)

BENEFITS: I am voluntarily receiving combined oral contraceptives (birth control pills) as a method of family planning, which I have chosen. I am aware that the oral contraceptives are not guaranteed to be 100% effective in preventing pregnancy. I understand that in addition to their benefit as a method of birth control, some women experience the following benefits from using birth control pills

***decreased menstrual cramps**
***decreased menstrual bleeding**
***decreased risk of pelvic infection**
***decreased risk of ovarian/endometrial cancer**
***more regular menstrual bleeding**
***improvement of acne**
***decreased risk of benign breast tumors/ovarian cysts**
***decreased risk of anemia**

RISKS/SIDE EFFECTS: I am aware that while using oral contraceptives, I may experience the following side effects, many of which are temporary: nausea, spotting between periods, weight gain, depression, breast tenderness, darkening of the skin on my face, worsening of acne, vaginal infections.

In addition to the above side effects, I understand that the birth control pills may be associated with blood clots of the legs or lungs, high blood pressure, strokes, heart attacks, gallbladder disease, liver tumors, and very rarely, death. The risk of heart attack is increased in women over 35 and women who smoke.

I understand that in order to lessen the chances of serious problems, it is **MY** responsibility to return to the clinic, to a doctor or to a hospital emergency room if I have any of the following symptoms:

***Abdominal pain**
***Headaches, dizziness, weakness, numbness**
***Severe leg pain (calf or thigh)**
***Chest Pain or shortness of breath**
***Eye problems (blurred vision or loss of vision)**

ALTERNATIVES: The other methods of contraceptives have been explained to me.

INSTRUCTIONS: For the use of the birth control pills have been given to me.

STOPPING PILLS: I understand that I may stop using the pills at any time. I understand that after stopping the combined oral pills, I should use another method of birth control until I have had three regular periods before I try to become pregnant.

QUESTIONS: I have been given the opportunity to ask questions about all forms of birth control, about birth control pills in particular, and about this form.

SMOKING: _____ Do or _____ Do not smoke
I understand that there is an increased risk of strokes, heart attacks, and blood clots for women who smoke and use birth control pills.

Print Name:_____

Client Signature:_____ Date_____

Staff Signature: _____ Date_____