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
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 Male Intake

Client Name	Date of Birth	Today's Date

I. HEALTH HISTORY	**Yes**	**No**	Don't Know	STAFF COMMENTS
Does anyone in your immediate family (mother, father, sister, brother) have a history of: (If yes, list who.)				
I am adopted (Please enter any information you have on your biological family; otherwise proceed to MEDICAL HISTORY				
1. Diabetes, sugar in blood or urine?				
2. High blood pressure?				
3. High blood cholesterol?				
4. Stroke?				
5. Heart attack, heart disease?				
6. Cancer? What type?				
7. Birth defects? Genetic disorders? What?				

II. MEDICAL HISTORY: Have you had the following immunizations (shots):

1. Hepatitis B				
2. Tetanus				

Do **YOU** have or have you ever had any of the following:	**Yes**	**No**	
3. Do you have allergies to food, medications, latex? Please list:			
4. Diabetes?			
5. Hepatitis, liver, or gallbladder disease?			
6. Bladder or kidney infection/disease or pain or bleeding with urination?			
7. Asthma, TB or other lung problems?			
8. High blood pressure?			
9. High blood lipids: cholesterol &/or triglycerides?			
10. Stroke or blood clots in the legs, lungs, head?			
11. Frequent indigestion, constipation, nausea or rectal problems?			
12. Heart disease, chest pain or shortness of breath?			
13. Conditions affecting penis, testicles or prostate?			
14. Problems with erection or ejaculation?			
15. Cancer? Where and when?			
16. Thyroid or other metabolic problems?			
17. Depression or any psychological problems?			
18. Seizures or Epilepsy?			
19. Have you had an operation or been hospitalized? When and why?			
20. Are you currently taking any prescription medications or over the counter (OTC) medications including vitamins, minerals, herbal or dietary supplements? Please list:			

Client Name: _____

	Yes	No	STAFF COMMENTS
21. Are you circumcised?			

III. LIFESTYLE HISTORY	**Yes**	**No**	
1. Do you check your testicles for lumps?			
2. Do you drink alcohol? How much? How often?			
3. Do you use tobacco products (cigarettes or chew)? How much per day? How long? Months: Years:			
4. Do you use street drugs (marijuana, cocaine, crack, meth)? What kind? How often?			
5. Do you have any concerns that you may have an eating disorder?			
6. Are you now or have you ever been in a relationship with a person who threatens or physically (hit, slap, kick or otherwise) hurts you?			
7. Has anyone ever forced you to have sexual activities that made you uncomfortable / forced you to have sex?			

IV. CONTRACEPTIVE HISTORY	**Yes**	**No**	
1. Are you and / or your partner currently using any method of birth control? If yes, what?			
2. Are you having any problems with this method? Would you like information about another method?			

VI. SEXUAL/ REPRODICTUVE HISTORY (Including STD/HIV Risk Factors)	**Yes**	**No**	
1. Are you having sex with someone? If yes, male _____female _____both_____			
2. How many partners have you had in the past 6 months? ___			
3. Does your partner(s) have sex with: ___ women &/or ___ men			
4. How old were you when you first had sex? Age: _____			
5. Have you ever been treated for a sexually transmitted disease (STD) or sexually transmitted infection (STI)?			
6. Do you have any symptoms of an STD / STI now (rash, sores, bumps, discharge or burning with urination)?			
7. Have you / your partner(s) ever used intravenous (IV) drugs?			
8. Have you / your partner(s) had a blood transfusion?			
9. Are you concerned that you may have been exposed to the AIDS virus?			
10. Do you have any biological children?			
11. Do you plan to have children in the future?			

The information I have provided on this form is correct and complete to the best of my knowledge.

_____ (client's signature)

Name of Clinic Staff Member that reviewed this form: _____