Reproductive Healthcare of the Big Horns

General Consent for Services

Client Name(printed) _____Medical Chart ID: _____

I hereby consent to receive medical and related services from the Reproductive Healthcare of the Big Horns Program staff, who are qualified and adequately trained to provide such services. These services may include reviewing my health history, health information, education, and counseling. Medical exams and screenings may be needed for breast and cervical cancer, mental health, behavioral risks, personal safety, sexually transmitted infections, including HIV, and referrals for care not provided at this clinic. Based on the findings, I also understand that follow-up examinations or additional tests may be recommended.

I understand that I will be provided with information about the test(s), procedure(s), treatment(s), and family planning method(s) before any of these services are provided. This information includes benefits, risks, possible problems or complications, and alternate choices. I know I should ask questions about anything I do not understand.

I understand that my receipt of family planning services is voluntary. I can change my mind about receiving these services at any time. No guarantee has been given to me as to the results that may be obtained from any service I receive. I know that my acceptance of family planning services is not a prerequisite for the receipt of other services offered at this site.

I understand that I am eligible to receive services from this clinic regardless of my religion, race, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies, marital status, or inability to pay. I understand I have the right to receive language interpreter and translation services at no cost.

I also understand that my medical services and records are confidential and will be disclosed to others only with my written consent or as otherwise required by law, such as reporting child abuse/neglect cases, court orders, abnormal laboratory results, or medical findings that may jeopardize my health. If tests are done for any sexually transmitted infections, including HIV, reporting positive results from those tests to public health agencies is required by law.

My signature on this form indicates that I received or was offered a copy of the Notice of Privacy Practices. I understand that I may request a copy of the Privacy Notice anytime.

I understand that every reasonable attempt will be made to contact me regarding my healthcare. I understand it is my responsibility to provide the clinic with contact information where I can be reached and update it as necessary.

If my visit is covered by insurance or other third-party payer, I authorize Reproductive Healthcare of the Big Horns to release the medical information necessary to determine benefits payable under this claim. I authorize payment of medical benefits to the provider or supplier of services rendered. I understand I am financially responsible for this bill according to my reported income level, regardless of insurance coverage.

I certify that I have read and understand the above and voluntarily consent to the services and supplies provided by this clinic.

Client Signature_____ Date_____

Staff Signature_____ Date_____

FOR MINORS (under the age of 18) ONLY:

It is a Legislative Mandate that, to the extent possible, this clinic shall encourage family participation in the decision of minors to seek family planning services and to provide counseling on how to resist attempts to coerce minors into engaging in sexual activities. Also, notwithstanding any other provision of law, no provider of services under Title X of the PHS Act shall be exempt from any State law requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest.

My signature acknowledges that I was encouraged to involve my family in my decision to seek family planning services, was counseled on how to resist attempts of coercion into engaging in sexual activities, and was informed about mandatory reporting of child abuse, child molestation, sexual abuse, rape, or incest.

Client Signature_____ Date_____

Staff Signature_____ Date_____

(To be signed after the medical visit in which the counseling was provided)

REPRODUCTIVE HEALTHCARE OF THE BIG HORNS
NOTICE OF PRIVACY PRACTICES
EFFECTIVE DATE: APRIL 14, 2003

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.

The Reproductive Healthcare of the Big Horns (RHBH) collects information about your health that is private. RHBH is required to protect this information by Federal and State law. This information is called "protected health information" or PHI.

The notice of Privacy Practices will tell you how RHBH may use or disclose information about you. Not all situations will be described. RHBH is required to give you a notice of our privacy practices for the information we collect and keep about you. RHBH is required to follow the terms of the notice currently in effect.

In the future, RHBH may change its Notice of Privacy Practices. Any changes will apply to information RHBH already has, as well as any information RHBH receives after changes have been made. A copy of the new notice will be posted at each RHBH site and facility and provided as required by law. You may ask for a copy of the current notice anytime you visit RHBH, or get it online at www.wyhc.org.

RHBH MAY USE AND DISCLOSE INFORMATION WITHOUT YOUR AUTHORIZATION

- For Treatment: RHBH may use or disclose information with health care providers who are involved in your health care at the Family Planning Clinic in which you are currently enrolled as a client.
- For Payment: RHBH may use or disclose information to get payment or to pay for health care services you receive. For example, RHBH may provide PHI to bill your health plan for health care provided to you.
- For Health Care Operations: RHBH may use or disclose information in order to manage its programs and activities. For example, RHBH may use PHI to review the quality of the services you receive.
- Appointments and Other Health Information: RHBH may send you reminders for medical care or checkups. RHBH may send you information about health services that may be of interest to you.
- Public Health Activities: RHBH keeps records in order to track some diseases.
- As Required by Law and for Law Enforcement: RHBH will use and disclose information when required or permitted by federal or state law or by a court order.
- For Abuse Reports and Investigations: RHBH is required by law to receive and investigate reports of abuse.
- To Avoid Harm: RHBH may disclose PHI to law enforcement in order to avoid a serious threat to health and safety of a person or the public.
- For Research: RHBH uses information for studies and to develop reports. These reports do not identify specific people.

Other Uses and Disclosures Require You Written Authorization

For other situations, RHBH will ask for your written authorization before using or disclosing information. You may cancel this authorization at any time in writing. RHBH cannot take back any uses or disclosures already made with your authorization.

- We may disclose PHI to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services, i.e., a company that performs billing services.
- We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.
- We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.
- If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Your PHI Privacy Rights

- Right to See and Get Copies of Your Records. In most cases, you have the right to look at or get copies of your records, electronic or paper records. You must make the request in writing. You may be charged a fee for the cost of copying your records.
- Right to Request or Correct or Update Your Records. You may ask RHBH to change or add missing information to your records if you think there is a mistake. You must make the request in writing, and provide a reason for your request.
- Right to Get a List of Disclosures. You have the right to ask RHBH for a list of disclosures of your PHI, made after April 14, 2003. You must make the request in writing. This list will not include the times that information was disclosed for treatment, payment, or health care operations. The list will not include information provided directly to you or your family, or information that was sent with your authorization.
- Right to Request Limits on Uses or Disclosures of PHI. You have the right to ask that RHBH limit how your information is used or disclosed. You must make the request in writing and tell RHBH what information you want to limit and to whom you want the limits to apply. RHBH is not required to agree to the restriction. You can request that the restrictions be terminated in writing or verbally.
- Right to Revoke Permission. If you are asked to sign an authorization to use or disclose information, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared.
- Right to Choose How We Communicate With You. You have the right to ask that RHBH share information with you in a certain way or in a certain place. For example, you may ask RHBH to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain the basis for your request.
- Right to File a Complaint. You have the right to file a complaint if you do not agree with the manner in which RHBH has used or disclosed information about you.
- Right to Get a Paper Copy of this Notice. You have the right to ask for a paper copy of this notice at any time.

How to Contact RHBH to Review, Correct, or Limit Your Protected Health Information (PHI)

You may contact your local Title X Family Planning Program office or the RHBH Privacy Officer at the address listed at the end of this Notice to:

- Ask to look at or copy your records.
- Ask to limit how information about you is used or disclosed.
- Ask to cancel your authorization to disclose information.
- Ask to correct or change your records.
- Ask for a list of the times RHBH disclosed information about you.
- File a complaint.

RHBH may deny your request to look at, copy, or change your records. If RHBH denies your request, RHBH will send you a letter that tells you why your request is being denied and how you can ask for a review of the denial. You will also receive information about how to file a complaint with RHBH or with the U.S. Department of Health and Human Services.

How to File a Complaint or Report a Problem

You may contact any of the people listed below if you want to file a complaint or to report a problem with how RHBH has used or disclosed information about you. Your benefits will not be affected by any complaints you make. RHBH cannot retaliate against you for filing a complaint, cooperating in an investigation, or refusing to agree to something that you believe to be unlawful.

For More Information

If you have any questions about this Notice or need more information, please contact,
Rob Johnston, Executive Director, Wyoming Health Council
400 East First Street, Suite 313 Casper, WY 82601
Phone: 307-439-2033 Email: rjohnston@wyhc.org

I have read/reviewed and been given a copy of this Notice of Privacy Practices.

_____ _____

Client/Patient Date

_____

Witness

Reproductive Healthcare of the Big Horns
128 S. THURMOND
SHERIDAN, WY 82801

PATIENTS BILL OF RIGHTS AND RESPONSIBILITIES

You have the right 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, concise explanation in lay person's terms of all proposed procedures 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.
- 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 her/his **dignity** as a human being. Success in achieving this recognition assures success in defense of the rights of the patient.

Client Signature _____ Date _____ Staff Signature _____

Reproductive Healthcare of the Big Horns

Client Name	Age	Date of Birth	Today's Date

I. Do you have any ALLERGIES to food or medication? Please list: _____

II. Medical History: Have you had the following immunizations (shots): **COMMENTS**

☐ Rubella (measles) ☐ Tetanus ☐ Varicella/Chicken Pox			
☐ Hepatitis B ☐ HPV ☐ Meningococcal			

Circle if you have or have ever been diagnosed with any of the following:

1. Anemia? Diabetes? High Blood Pressure? High cholesterol?	Yes	No	
2. Blood clots in legs, lungs, head? Heart Disease, stroke?	Yes	No	
3. Thyroid problems, PKU?	Yes	No	
4. Urinary tract (bladder) or kidney infection?	Yes	No	
5. Headaches, migraines w/vision changes, seizures or epilepsy?	Yes	No	
6. Asthma? Tuberculosis or other lung disease?	Yes	No	
7. Breast problems? Cancer? Where and when?	Yes	No	
8. Hepatitis, liver, gallbladder disease?	Yes	No	
9. Depression or other mental health concerns?	Yes	No	
10. **Have you had an operation or been hospitalized? When? Why?**	Yes	No	
11. Are you taking any prescriptions or over the counter medications, including folic acid, calcium, vitamins or supplements? Please list.	Yes	No	
12. Are there any other health issues we need to know about? Please include learning disabilities, physical or mental issues.	Yes	No	

III. FAMILY HEALTH HISTORY **COMMENTS**

Does anyone in your immediate family (mother, father, sister, brother, child) have a history of: (If yes, list who)				
****I am adopted** (Please enter any information you have on your biological family: otherwise proceed to LIFESTYLE HISTORY)				
1. Diabetes, sugar in blood or urine?	Yes	No	Unsure	
2. High blood pressure, stroke, heart attack, heart disease?	Yes	No	Unsure	
3. High blood cholesterol? Cancer? What type?	Yes	No	Unsure	
4. Birth defects? Genetic disorders? What are they?	Yes	No	Unsure	
5. Clotting disorders?	Yes	No	Unsure	
6. Did your mother use DES while pregnant with you?	Yes	No	Unsure	

IV. LIFESTYLE HISTORY **COMMENTS**

1. Do you visit a dentist at least one a year?	Yes	No	
2. Do you drink alcohol? How much? How often? Last time?	Yes	No	
3. Do you use tobacco products (cigarettes or chew)? How much per day? _____ How long have you been smoking/using chew? Months? Years?	Yes	No	
4. Do you use street drugs (marijuana, cocaine, crack, meth)? What kind? How often? Last time?	Yes	No	
5. Are you concerned about your diet or eating habits? Anorexia/Bulimia? Other?	Yes	No	
6. Are you now or ever been in a relationship with a person who threatens or physically hurts you (hit, slap, kick or otherwise)?	Yes	No	
7. Has anyone ever forced you to have sexual activities that made you uncomfortable?	Yes	No	

Name: _____

V. CONTRACEPTIVE HISTORY	COMMENTS
1. What methods of birth control have you used in the past? ☐ Pill ☐IUD ☐Patch ☐ Abstinence ☐Natural ☐Sponge ☐Sterilization ☐Diaphragm ☐Condoms ☐Depo Provera shot ☐Spermicidal (foam) ☐EC/Plan B ☐Pulling out ☐Ring ☐None ☐Other	
2. What method are you using now?	
3. Are you having any problems with your current method?	
4. What method would you like to use?	

VI. MENSTRUAL/GYNECOLOGICAL HISTORY			COMMENTS
1. How old were you when your first period started?			
2. How often do you get your period?			
3. How many days does your period last?			
4. What was the first day of your last period?			
5. Do you have pain/cramps or other problems with your period?	Yes	No	
6. Do you bleed between periods?	Yes	No	

VII. SEXUAL HISTORY (Including STD/HIV risk factors)			COMMENTS
1. When was your last Pap smear?			
2. Have you ever had an abnormal Pap?	Yes	No	
3. Do you have sex with men, women or both?			
4. How long have you been with your current partner?			
5. How many sexual partners in the past six months?			
6. Do your partner (s) have other sexual partners besides you? If so, are they: women men	Yes	No	
7. Do you have pain or bleeding or any other difficulty with sex?	Yes	No	
8. Have you ever been treated for a sexually transmitted infection (Chlamydia, Gonorrhea, warts, HPV, HIV)	Yes	No	
9. Do you have any discharge, rashes, sores, bumps, itching? (Circle)	Yes	No	
10. Have you/your partner(s) ever used intravenous (IV) drugs?	Yes	No	
11. Have you/your partner(s) had a blood transfusion?	Yes	No	
12. Do you want STD or HIV testing?	Yes	No	

VIII. PREGNANCY HISTORY	Yes	No	
1. Have you ever been pregnant?	Yes	No	
2. List the number and dates of: Full term _____ Premature or low birth weight _____ Abortion/Miscarriage/Still birth _____ Living children			Complications?
3. Do you desire a pregnancy in the future? If yes, when?	Yes	No	
4. Do you have a primary care doctor or clinician	Yes	No	Name of doctor or clinician:

Do you have any other health concerns that you want to discuss with us today? Please list or tell the nurse.

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

_____(client's signature)

Signature of clinic staff: _____ Date _____(Updated 6.2012)

Updated 8/2010

Application for Reproductive Healthcare of the Big Horns Services
Personal & Financial Inventory

Name: _____ Email:_____

Phone: _____ Alternate phone: _____

Mailing Address: _____

City/State/Zip: _____

ARE YOU INSURED?_____ IF SO, NAME OF INSURANCE COMPANY:_____

I am: ____Single ____Married ____Divorced ____Living with Partner ___Other

EMERGENCY CONTACT: _____

Relationship to you: _____

Address: _____

Phone: _____

Name and age of all members of your household:

Name:_____Age: _____ Name:_____ Age: _____

Name:_____Age: _____Name:_____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Gross monthly income for each household member including you:

You	**Name:**	**Name:**	**Name:**	**COPIES needed**
$	$	$	$	Current Employment Check Stub or Tax Return
$	$	$	$	Social Security Award Letter
$	$	$	$	Disability Award Letter
$	$	$	$	Public Assistance Check Stub
$	$	$	$	SSI Medicaid Coupon

$	$	$	$	Child Support Divorce Decree or Bank Statement
$	$	$	$	Food Stamps Card
$	$	$	$	Unemployment Check Stub

I am aware that my chart may be audited or reviewed for financial or regulatory purposes

Patient Signature:_____

DATE: _____

Reproductive Healthcare of the Big Horns Signature Sheet

Name:_____ **DOB:**_____

Please initial on line before statements:

_____ **HIPAA Notice & Patient Bill of Rights & Responsibilities:**

I have reviewed the posted Reproductive Healthcare of the Big Horns HIPAA Notice of Privacy Practices and Patient Bill of Rights and Responsibilities statements. A copy is available upon request.

_____ **Insurance Assignment of Benefits Authorization**

I authorize Reproductive Healthcare of the Big Horns to disclose medical or other information required to process claims. I understand that third party payers will be billed full price for services received. If charges are denied by insurance, a balance due adjustment will be made by RHBH according to the appropriate individual fee scale. I understand that payments from third—party payers will be made directly to Reproductive Healthcare of the Big Horns. All balances will be my financial responsibility.

_____ **Statement of Personal & Financial Inventory**

I certify that I have provided true and accurate personal and financial information to be used by Reproductive Healthcare of the Big Horns to determine my eligibility for grants and the RHBH sliding fee scale.

My signature acknowledges receipt, review, and agreement with all of the above information and directives.

Signature:_____ **Date:** _____