Tri-Rivers Family Planning, Inc.

1032 Kingshighway, Rolla, MO 65401 573.364.1509
2545 Bagnell Dam Blvd. Suite 209, Lake Ozark, MO 65049 573.365.3244

DATE:_____ DATE OF BIRTH:_____ AGE: _____

NAME:_____ S.S.#:____/_____/_____

ADDRESS:_____ CITY:_____ STATE: ____ ZIP:_____

COUNTY:_____ HOME/CELL PHONE:_____ WORK PHONE:_____

PLEASE COMPLETE IF YOU HAVE A PERMANENT ADDRESS OTHER THAN ABOVE

ADDRESS:_____CITY: _____ STATE: ____ ZIP: _____
COUNTY:_____ HOME PHONE:_____

CONFIDENTIALITY MAY BE BROKEN IF A LIFE THREATENING CONDITION IS SUSPECTED OR DETECTED.

***How can we reach you? (For example, with test results.) WE MUST BE ABLE TO WRITE YOU IF YOU ARE USING MEDICAID OR OTHER INSURANCE TO PAY FOR YOUR CARE**

Call Home/Cell ___Yes ___No Call Work ___Yes ___No Mail (Plain Envelope) ___Yes ___ No
Email (Only if Yes) _____

*If you are less than 18, do your parents/guardians know that you get health care at TRFP?___Yes___No
*If you are 18 or older, do you live with your parents/guardians at any time during the year? ___ Yes ___ No

*Sex at birth: ____Female ____Male _____Intersex
*How do you identify now? _____Female _____Male _____Transgender _____Other_____
*What pronouns do you use? _____she/her _____he/his ____ they/their ____ Other _____
*Are you Hispanic/Latino/Latina? ____ Yes ____ No
*Circle Your Race(Circle All That Apply): White Black Native American/Alaska Native Asian Native Hawaiian/Other Pacific Islander
*Circle your marital status: Single Married Separated Divorced Living Together
*Are you a student? ___Yes ___ No If yes, where? _____

EMERGENCY CONTACT: (If you do not provide an emergency contact, we will not be responsible if we can't reach you about your test results.)
Name_____Relationship_____
Full Address:_____Phone ( )_____

Medical records will be destroyed after the elapsed time allowed by law.

I hereby certify that the above information is true and accurate to the best of my knowledge. I realize that this information is being given in connection with the receipt of federally subsidized health care. I further realize that deliberate falsification of this information may result in the termination of service.

PATIENT SIGNATURE:_____DATE:_____

STAFF SIGNATURE:_____ DATE:_____

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Financial Information

Thank you for choosing Tri-Rivers Family Planning (TRFP) as your health care provider. We are committed to providing the highest quality of care at the lowest possible cost. We require you to read and sign this statement to make sure that you are aware of our payment policies.

* Payment in full is required at the time of service.
* Most fees are determined by total household income and how many people are supported by that income.
* **If you refuse to provide us with income information you will be assessed as a full fee patient.**
* Cash, check, money order, and all major credit cards are accepted as payment. We also accept Medicaid and will file with private insurance.
* Just as you expect TRFP to be honest with you about your health care, we expect you to be honest with TRFP about your financial resources.
* **Donations to help us keep our doors open are greatly appreciated.**

Do you have private insurance? ___Yes ___ No (for example, Anthem, Tricare, United Healthcare, Healthlink)
Does your private insurance cover birth control? ____ Yes ____ No _____ I don't know
Do you have Medicaid? ___ Yes ___ No
Do you want to use your private insurance or Medicaid for the services you receive here? ____Yes ____No

If yes, we will need to make a copy of any card(s) you have to verify coverage. You may be responsible for a balance if your insurance does not pay. If your insurance company issues you a check after we have filed insurance on your behalf, you will reimburse TRFP for the full amount of the check. By signing this form, you are authorizing us to provide your insurance provider and its agents with any of the information needed to determine benefits payable for services rendered and to receive payment for those services on your behalf. This authorization is effective indefinitely unless you revoke this arrangement.

Do you have a job?__Yes__No **Your pay per hour $_____ Average number of hours worked per week _____**

Circle All Other Sources of Income: Spouse Partner Parents/Guardians Public Assistance Social Security Friend Relative Child Support Tips Unemployment Workers Comp Allowance
Other_____

Total weekly income from all sources before taxes_____
Number of people supported by this income_____

I certify that my participation is completely voluntary and that the above information is true to the best of my knowledge. I realize that this information is being given in connection with the receipt of federally subsidized health care. I further realize that deliberate falsification of this information may result in the termination of service.

PATIENT SIGNATURE:_____ DATE:_____
STAFF SIGNATURE:_____ DATE:_____

**********STAFF USE ONLY **********

GROSS INCOME (BEFORE TAXES) MONTHLY: _____

OF PEOPLE SUPPORTED BY THIS INCOME: _____

____ MEDICAID (CARD REQUIRED)
_____ ME CODE 80/89

_____INSURANCE (CARD REQUIRED)
_____ COPAY AMOUNT

_____ LIMITED ENGLISH PROF.

FEE CATEGORY_____

HARDSHIP _____

Tri-Rivers Family Planning, Inc.

FEMALE HEALTH HISTORY

Patient Name _____ **Date** _____ **ID#** _____

Do you want to get pregnant in the next year? ☐ Yes ☐ No
Do you ever want to get pregnant? ☐ Yes: When? ☐ No
First day of last period: ☐ No longer have periods
Was it normal? ☐ Yes ☐ No - Details:
Age at first period:
Periods come every _____ days and last _____ days.
Periods are ☐ regular ☐ irregular ☐ painful ☐ light ☐ moderate ☐ heavy
Current birth control method:
Birth control method you want today: ☐ None
I have **ALLERGIES** to drugs or latex: ☐ Yes ☐ No
List:
I take **MEDICINE** or herbal supplements: ☐ Yes ☐ No
List:
Date of last Pap Smear: ☐ I have never had a Pap
Any abnormal Paps? ☐ Yes ☐ No Date:
Do you douche? ☐ Yes ☐ No Last time:
☐ Never pregnant. ☐ I have been pregnant _____ times.
Date my last pregnancy ended:
☐ I am breastfeeding.
List any major illnesses, surgeries, hospitalizations, and/or birth defects: ☐ None
List any chronic illnesses: ☐ None
I have had vaccinations: ☐ Measles/Mumps/Rubella ☐ Meningitis ☐ Hepatitis B ☐ HPV (Gardasil or Cervarix)
I use tobacco. ☐ Yes ☐ No If yes, for how long?
☐ cigarettes ☐ chewing tobacco How much a day?
I drink caffeine (coffee, tea, soda, energy drinks) regularly. ☐ Yes ☐ No
I drink alcohol. ☐ Yes ☐ No If yes, how many drinks a day?
Is anyone worried about your use of alcohol/other drugs? ☐ Yes ☐ No
I am under a lot of stress at home/work/school. ☐ Yes ☐ No
CHECK ALL THAT ARE TRUE FOR YOU
☐ Not sexually active/no current sex partner.
☐ New sex partner in last 60 days.
☐ More than 1 sex partner in last 12 months.
☐ I have other sex partners or my partner has other sex partners.
I have had/have a sexually transmitted disease ☐ Yes ☐ No ☐ chlamydia ☐ gonorrhea ☐ herpes/coldsores ☐ syphilis ☐ HIV ☐ hep B ☐ hep C ☐ genital warts/HPV ☐ Trich
My partner had/has a sexually transmitted disease ☐ Yes What? _____ ☐ No ☐ Don't know
Sex Partners: ☐ Male ☐ Female ☐ Transgender
Sex: ☐ Oral ☐ Vaginal ☐ Anal
Condom Use ☐ Always ☐ Sometimes ☐ Never
☐ I share/have shared needles or used injection drugs.
☐ Current/previous partner shares/has shared needles or used injection drugs.

CHECK ALL THAT ARE TRUE FOR YOU
☐ Bladder, kidney or urinary tract infections/problems **Now?**
☐ Incontinence
☐ Vaginal or pelvic infections/pain/PID **Now?**
☐ Uterine fibroids/uterine abnormality
☐ Breast lump or discharge/breast disease **Now?**
☐ Vaginal discharge that itches/burns or has a bad smell **Now?**
☐ Problems with vaginal muscles or severe constipation
☐ Endometriosis
☐ Pain with sex or problems with sex **Now?**
☐ Vaginal bleeding after sex/ bleeding between periods **Now?**
☐ Mitral valve prolapse
☐ Heart murmur/heart disease
☐ Varicose veins
☐ Blood clots (head/lungs/legs) ☐ In my family
☐ Stroke or heart attack ☐ In my family
☐ High blood pressure ☐ In my family
☐ High cholesterol ☐ In my family
☐ Palpitations/irregular heartbeat/chest pain
☐ Chronic cough or other breathing problems/asthma
☐ Tuberculosis or exposure to tuberculosis
☐ Depression /anxiety/eating disorder
☐ GI problems/gallbladder problems/liver problems
☐ Lupus
☐ Seizure disorder/epilepsy
☐ Bone problems/osteoporosis
☐ Thyroid problems
☐ Diabetes/gestational diabetes ☐ In my family
☐ Migraines diagnosed by a doctor - If yes, do you ever have vision changes that ☐ start before the headache starts ☐ last up to one hour ☐ stop before the headache starts
☐ I have/have had cancer. If Yes, details:
☐ A person in my immediate family has/has had cancer. If yes, details:
☐ I have had weight loss surgery in the last 2 years. If yes, details:
☐ I recently had surgery/am planning a surgery that will require long-term bed rest. If yes, details:
☐ I have received an organ from a donor.
☐ I have had a blood or plasma transfusion.
CLIENT SIGNATURE/DATE
X

Reviewed October 2019

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REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Before you give your consent, be sure you understand the information 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 I need a language interpreter to understand the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and TRFP may need to refer me to another health care facility to provide the services necessary for my care.

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 TRFP and withdraw my consent. I know that I do not have to have family planning services in order to be a client at TRFP.

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 understand that HIV testing will be done unless I opt out.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care.

I understand that confidentiality will be maintained as described in Tri-Rivers Family Planning'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 TRFP provide healthcare services, including the appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

Please note that TRFP is a teaching institution, and that persons in training, under strict supervision, may be involved in some aspects of your care.

I hereby acknowledge receipt of Tri-Rivers Family Planning's notice of health information privacy practices. I choose _____ to be my personal representative. If something happens to me and I am not able to care for myself, this person may authorize records releases of my personal health information, and may also receive personal health information that would have been sent to me.

I understand that if TRFP is closed and I have a medical emergency, I should contact my family physician, go to the emergency room, or call 911.

Signature of patient _____

Date _____ Patient # _____

Signature of staff _____

Date _____