For the safety and privacy of our patients and staff members, we **DO NOT** allow cell phone use in this facility, EXCEPT LIMITED cell phone use in our upstairs waiting area. There are **NO** exceptions.

There is absolutely NO video/recording, photography, phone calls, or audio allowed by you or your guest.

Violators will be asked to leave.

Please sign below to affirm that you have read and understand the privacy statement on the back of this page, and you agree to our terms and regulations.

Signature: _____ Date: _____

Print Name: _____

Revised 07/2018

Notice of Privacy Practices and Patient Rights

Federal guidelines (HIPAA) dictate the protection of your medical information, how it may be used, disclosed, and how you can have access to this information. This notice includes information regarding your rights as a patient to make decisions about your medical care.

We are committed to protecting the privacy of your health record and the confidentiality of your visit. Your healthcare record (chart) and the information it contains will not be disclosed to anyone or any outside agency without written authorization from you unless such a release is required by law or in a medical emergency or medical treatment.

We will use your health information for the purpose of:

- Treatment: Information obtained by staff will be used to determine your best course of treatment.
- Insurance: If you provide insurance, a claim will be filed and sent to your insurance company with information that identifies you, as well as your diagnosis and treatment.
- Healthcare operations: We may share your information with other healthcare providers to assist them in helping you (e.g. If you follow-up with your physician after your abortion care).
- We may disclose medical information as required by law (e.g. to the Food and Drug Administration [FDA] relative to adverse events such as product defects or product recalls).
- To public health or legal authorities charged with preventing or controlling disease, injury, domestic abuse, child abuse or neglect.
- For law enforcement purposes such as in response to a valid subpoena.

Your Rights as a Patient

Your health and wellbeing depend on a collaborative effort between you and our staff in a mutually respectful alliance. You contribute to this alliance when you fulfill your responsibility as a patient when seeking care and being candid with the physician by providing a truthful and complete medical history.

The physicians and staff can best contribute to a mutually respected alliance by serving as your advocate and by respecting your rights as a patient. These include the right:

- to courtesy, respect, dignity, and timely, responsive attention to your needs.
- to receive information from you and to have opportunity to discuss the benefits, and risks of appropriate treatment alternatives, including the risks, and benefits of forgoing treatment.
- to expect the physician to provide guidance about what he or she may consider the optimal course of action for you based on the physician's objective professional judgement.
- to ask questions about your health status or recommend treatment when you do not fully understand what has been described and to have your questions answered.
- to make decisions about the care the physician recommends and to have those decisions respected. You may accept or refuse any recommended medical intervention.
- to have the physician and staff respect your privacy and confidentiality.
- to obtain a second opinion.

Although your health record is the physical property of the facility you have the right to:

- request restriction on certain uses and disclosures of your information.
- obtain a copy of your health record and an accounting of disclosures of your health information.
- revoke your authorization to use or disclose health information except to the extent that action has already been taken. All requests must be in writing.

We reserve the right to change practices and to make the new provision effective for all protected health information we maintain

If you have questions, or if you want to report a problem, please contact our Privacy Officer at (301) 251-9124. Complaints may also be filed with the secretary of health and human services (866) 627-7748.

REGISTRATION FORM

Please Turn Off All Cell Phones

Service Requested:

Surgical Abortion: □ Local (Awake) □ General (Asleep) □ Twilight (Conscious Sedation)

□ Medical (Pill) Abortion

Other: □ Sonogram □ Pap smear □ Blood Pregnancy Test □ IUD Insertion

Last Name _____ First Name_____

Marital Status _____ Race/Ethnicity _____

Address _____

City _____ State _____ Zip Code _____

Phone Number ( ) _____ Email Address _____

Age _____ Date of Birth (mm/dd/yy) _____/_____/_____

Employer _____Occupation _____

Emergency Contact Name _____ Relationship _____

Emergency Contact's Phone Number ( ) _____

What was the first day of your last normal period? _____

Have you had a sonogram/ultrasound for this pregnancy? Yes No

Date of sonogram: _____ Weeks (at time of sonogram): _____

Where was the sonogram performed? _____

How did you hear about us? (CIRCLE)

Online Friend Returning Dr.(name):_____ Other:_____

Payment:

□Cash □Credit/Debit Card □Funding/Pledge

□MD Medicaid □Commercial/Private Insurance (must have prior verification)

Please sign below to confirm that all of the above information is accurate and complete.

Signature: _____ Date: _____

Potomac Family Planning Center

Patient Health Questionnaire

For your safety please answer the questions accurately. Let us know if you do not understand or are not sure.

Name: _____ Age: _____ Height: _____ Weight: _____

Are you allergic to LATEX? Y N **Are you BREASTFEEDING? Y N**

List all allergies:	List all medication you take now:	List all surgeries you had:	Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What is the first day of your last period? _____

Have you experienced bleeding with this pregnancy? Y N

What time did you last eat or drink? _____

Number of previous: Live births: _____ Abortions: _____ Still births: _____ Miscarriages: _____ Ectopic: _____
Have you had a C-section? Y N

Circle yes (Y) to the questions that apply to you only (if yes, please explain):

Y N 1. Have you ever had an anesthetic? LOCAL or GENERAL
Any problems? _____

Y N 2. Have you ever had a problem with anesthesia?
If yes, explain: _____

Y N 3. Do you smoke? If yes, how many cigarettes per day and for how many years? _____

Y N 4. Have you been diagnosed with asthma?
Last attack _____
Do you have an inhaler? _____

Y N 5. Have you ever had an abnormal chest x-ray?
When? _____

Y N 6. Have you ever had difficulties breathing?
When? _____

Y N 7. Do you have a heart murmur?
_____

Y N 8. Have you ever had a heart attack?
When? _____

Y N 9. Have you ever had an abnormal EKG?
When? _____

Y N 10. Have you ever had high blood pressure? With pregnancy? _____

Y N 11. Have you ever had kidney disease?
_____

Y N 12. Have you ever had problems with liver function?
_____

Y N 13. Have you had cancer? What type?
_____

Y N 14. Have you ever had hepatitis?
_____

Y N 15. Do you consume alcohol? (If yes, how much and how often?) _____

Y N 16. Do you have acid reflux?
_____

Y N 17. Have you ever had a stroke?
When? _____

Y N 18. Have you ever had seizures?
When? _____

Y N 19. Have you ever had episodes of unconsciousness or fainting? _____

Y N 20. Do you have diabetes?
_____

Y N 21. Have you ever had thyroid problems?
_____

Y N 22. Do you have any physical disabilities?
_____

Y N 23. Have you ever had any blood clots in your lungs or legs? _____

Y N 24. Do you have any bleeding problems/ disorders?
_____

Y N 25. Have you ever been anemic?
_____

Y N 26. Have you used aspirin in the last two weeks? If so how much? _____

Y N 27. Do you have any of the following? (Circle)
braces chipped/loose teeth dentures caps/bridges

Y N 28. Have you ever been in the care of a psychiatrist?
_____

Y N 29. Have you ever used any street drugs?
_____

Y N 30. Have you ever had a sexually transmitted disease?
_____

31. What birth control methods have you used? Pill IUD NuvaRing Patch Condoms Depo Provera (shot)
Any problems: _____

32. Please list anything about your health we did not ask: _____
_____

My answers are accurate and complete to the best of my knowledge.

Patient Signature: _____ Date: _____

Revised 07/2018