Feminist Women's Health Center
Patient Privacy Notice Authorization

In order to comply with new federal guidelines outlined in the Health Insurance Portability & Accountability Act of 1996 (HIPAA), a Federal law which seeks to protect the privacy of consumers' healthcare information, we are advising you of your right as to how your medical information may be used.

The *NOTICE OF PRIVACY PRACTICES* located in the waiting rooms of the clinic outlines how personal information about you may be used and how you can get access to this information. If you would like a paper copy of the *NOTICE OF PRIVACY PRACTICES* please ask and we will be glad to provide you with one.

In accordance with the HIPPA Privacy Rule 45 CFR164.506 if you use a credit card to pay for services at Feminist Women's Health Center and subsequently dispute those charges with your banking institution/credit card holder, FWHC has the right to release some portions of your medical record should a financial dispute occur. By signing his form I certify that I fully understand this Privacy Notice and the rights of both myself and the FWHC.

I authorize the Feminist Women's Health Center to communicate medical information pertaining to my care by the methods outlined in the *NOTICE OF PRIVACY PRACTICES*. I am aware that I may ask for a paper copy of the *NOTICE OF PRIVACY PRACTICES* at any time.

Client signature_____

Witness_____

Valuables disclaimer (all patients must sign or be rescheduled):

- I attest that I deposited my valuables with my driver or otherwise secured them to the best of my ability.
- I release Feminist Women's Health Center from any liability from lost or stolen property.
- I attest that I do not have any removable appliances in my mouth.

Client Signature _____

Witness _____

Feminist Women's Health Center
Request for Information

Please help us better serve you by filling out the information below; the questions on the next two pages are optional.

1. Please indicate your race:

- ☐ Asian Pacific Islander
- ☐ Asian/Asian American
- ☐ Bi-Racial (Other)
- ☐ Bi-Racial (Person of Color)
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ Multi-Racial (Other)
- ☐ Multi-Racial (Person of Color)
- ☐ Native American
- ☐ White/Caucasian
- ☐ Other/Unknown

2. Please indicate your primary language:

- ☐ Arabic
- ☐ Bosnian
- ☐ Cakchikel
- ☐ Chinese
- ☐ English
- ☐ French
- ☐ German
- ☐ Hindi
- ☐ Japanese
- ☐ Korean
- ☐ Mixtec
- ☐ Portuguese
- ☐ Punjabi
- ☐ Quiche'
- ☐ Russian
- ☐ Spanish
- ☐ Vietnamese
- ☐ Zapotec
- ☐ Other

3. Please indicate your religion:

- ☐ Agnostic
- ☐ Atheist
- ☐ Baptist
- ☐ Buddhist
- ☐ Catholic
- ☐ Christian
- ☐ Church of Christ
- ☐ Episcopalian
- ☐ Evangelist/Fundamentalist
- ☐ Hindu
- ☐ Jehovah's Witness
- ☐ Jewish
- ☐ Lutheran
- ☐ Methodist
- ☐ Mormon/Latter Day Saints
- ☐ Muslim
- ☐ Presbyterian
- ☐ Quaker
- ☐ Unitarian
- ☐ Wiccan
- ☐ Other

4. Please indicate any temporary or permanent physical challenges you may have:

- ☐ None
- ☐ Blind
- ☐ Breathing Impaired
- ☐ Deaf
- ☐ Limited Range of Motion
- ☐ Multiple Disabilities
- ☐ Mute
- ☐ Non-Ambulatory
- ☐ Other

5. Please indicate your relationship status:

- ☐ Divorced
- ☐ Widowed
- ☐ Married
- ☐ Partnered
- ☐ Legally Separated
- ☐ Single

6. Please indicate your national origin:

- ☐ Afghani
- ☐ African (Country Not Listed)
- ☐ American
- ☐ Asian (Country Not Listed)
- ☐ Bosnian
- ☐ Brazilian
- ☐ Carribean (Non-Puerto Rican)
- ☐ Chinese
- ☐ Colombian
- ☐ Cuban
- ☐ Declined To Indicate
- ☐ Egyptian
- ☐ Ethiopian
- ☐ Guatemalan
- ☐ Indian
- ☐ Iranian
- ☐ Iraqui
- ☐ Japanese
- ☐ Korean
- ☐ Mexican
- ☐ Middle Eastern (Country Not Listed)
- ☐ Moroccan
- ☐ Native American
- ☐ Nigerian
- ☐ Other
- ☐ Pakistani
- ☐ Puerto Rican
- ☐ Russian
- ☐ Salvadorian
- ☐ Somalian
- ☐ South African
- ☐ South American (Country Not Listed)
- ☐ Sudanese
- ☐ Thai
- ☐ Vietnamese

7. Please indicate the combined annual income level for your entire household:

- ☐ Less than $12,250
- ☐ $12,251 - $15,500
- ☐ $15,501 - $20,750
- ☐ $20,751 - $25,000
- ☐ $25,001 - $29,250
- ☐ $29,251 - $33,500
- ☐ $33,501 - $37,750
- ☐ $37,751 - $42,000
- ☐ $42,001 - $50,000
- ☐ $50,001 - $75,000
- ☐ $75,001 - $100,000
- ☐ $100,001 - $150,000
- ☐ $150,001 - $200,000
- ☐ $200,001 - $250,000
- ☐ Greater than $250,000

8. Please indicate your sexual orientation:

- ☐ Bisexual
- ☐ Gay
- ☐ Heterosexual
- ☐ Lesbian
- ☐ Pansexual
- ☐ Queer
- ☐ Questioning
- ☐ Other

9. Please indicate the number of family members in your household, including yourself:

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ More than 10

10. Please indicate your level of education:

- ☐ Currently in Middle/High School
- ☐ Did Not Graduate High School
- ☐ High School Graduate/GED
- ☐ Two Year Undergraduate Degree
- ☐ Four Year Undergraduate Degree
- ☐ Post Graduate Degree

Please indicate how you found out about the Feminist Women's Health Center:

- ☐ Abortion Clinic Directory (online)
- ☐ Abortion Clinics Online
- ☐ Atlanta Latino
- ☐ Been Here Before
- ☐ Billboard
- ☐ Community Organization
- ☐ Creative Loafing
- ☐ Dekalb Rape Crisis Center
- ☐ Discount Coupon
- ☐ Friend
- ☐ Gay Yellow Pages
- ☐ Health Department
- ☐ Health Fair/Table
- ☐ In-Site Magazine
- ☐ Insurance Provider
- ☐ International Rescue Committee
- ☐ Mental Health Professional
  - Name: _____
  - Location: _____
- ☐ NAF Hotline
- ☐ Physician
  - Name: _____
  - Location: _____
- ☐ Planned Parenthood
- ☐ Refugee Family Services
- ☐ Refugee Women's Network
- ☐ Southern Voice
- ☐ Tapestri
- ☐ Website (FWHC)
- ☐ Yellow Pages
- ☐ Other Internet Ads/Listing
- ☐ Other: Please Specify: _____

Feminist Women's Health Center's
Cliff Valley Clinic
Client Certification form

Today's Date, __/__/__

I, _____, request that an abortion be performed on me;
Printed name

I certify that I am _____ years of age, date of birth ___/____/_____.

I certify that:
I do not chose to view the state materials as at least twenty-four (24) hours before the abortion, the physician who is to perform the abortion, the referring physician, or his or her qualified assistant has told me, by telephone, in person, or by automated script on Date, __/__/__ Time, _____

- The probable gestation of the fetus or embryo based on my last menstrual period
- The particular medical risks to me of the procedure that is indicated by my probable gestation
- The medical risks to me if I carry this pregnancy to term
- That medical assistance benefits may be available to me for prenatal care, childbirth and neonatal care
- That the father would be liable for child support per Ga. Code 19-7-49
- That I have the right to review State supplied materials, on the State of Georgia Website (or printed materials in the clinic or by mail at least 24 hours before my appointment) that describe the fetal development of the unborn child, contain information on fetal pain and contains a list of agencies that provide alternatives to abortion and free ultrasounds.
- I consent to the particular abortion freely and without coercion of any person and I am not under the influence of any drug of abuse or alcohol
- I was provided the opportunity to ask questions about the abortion that will be performed and all of my questions have been answered to my satisfaction

I verify that this information is correct and accurate.

Client's Signature_____

Translator Signature_____

Witness Signature _____

Physician Signature_____

☐ **Or:** I chose to view the State written materials which results in another mandatory 24 hour wait period.

I will return to the clinic on the next available date _____ . Initials_____

Feminist Women's Health Center's
Cliff Valley Clinic

HB 147/Client Ultrasound Certification Form

*******As part of the pre-abortion process, we will perform an ultrasound. If for any reason you leave our facility after the ultrasound, you will be charged a 130 dollar ultrasound fee. ********

Description

In accordance with the "Women's Ultrasound Right to Know Act" Chapter 9A of Title 31 Official Code of Georgia annotated, relating to the "Women's Right to Know Act", facilities performing abortions in the state of Georgia must offer each woman seeking an abortion the opportunity to view an active image of the ultrasound and to hear the fetal heart tones if they are present and audible.

The **choice is yours** whether to look at the ultrasound or listen to the fetal heart tones. You are not required to look or listen.

Attestation:

I was offered the opportunity to look at the ultrasound and to hear the fetal heart tones (if present) today, _____.
DATE

I choose (check 1 box):

☐ **Not to look at** the sonogram ☐ **To look at** the sonogram

I choose (check 1 box):

☐ **Not to listen** to the fetal heartbeat ☐ **To listen** to the fetal heartbeat (if present)

I understand that this sonogram determines gestational age only and does not determine the presence or absence of any fetal malformation.

CLIENT SIGNATURE:_____ Date:_____

****

OFFICE USE BELOW THIS LINE

Fetal Ultrasound Report

Early Pregnancy Protocol:

# of Fetus: ☐ 0 ☐ 1 ☐ 2 ☐ 3

# of Sacs: ☐ 0 ☐ 1 ☐ 2 ☐ 3

YOLK SAC SEEN: ☐ YES ☐ NO

FHT: ☐ YES ☐ NO ☐ NOT SEEN

FIBROID: ☐ YES PLACEMENT_____

Abdominal Pain: ☐ YES ☐ NO

Bleeding since LMP: ☐ YES ☐ NO

L Adnexa ☐ MASS ☐ NO MASS

R Adnexa ☐ MASS ☐ NO MASS

Per: ☐ Pelvic Exam ☐ Vaginal U/S

PLACENTA: ☐ Anterior ☐ Posterior ☐ Fundal ☐ Previa

☐ Abdominal Ultrasound ☐ Transvaginal Ultrasound

FL: _____ **BPD:** _____ **CRL:** _____ **WEEKS:** _____

HEIGHT: ____**ft** ____**in** **WEIGHT:** _____ **lbs.** **BMI:** _____

ULTRASOUND TECHNICIAN:_____

MD SIGNATURE:_____

FEMINIST WOMEN'S HEALTH CENTER
MEDICAL HISTORY

Date ____/____/_____

Legal Name _____ Preferred Pronoun (he/she/ze) _____
Preferred Name_____ DOB ____/____/_____ Age _____
Address _____ Apt # _____ Phone (c) (___)____-_____
City _____ Within City Limits: Yes ☐ No ☐ (h) (___)____-_____
County _____ State _____ Zip _____ (w) (___)____-_____
At what phone # may we contact you?_____ May we leave a message: Yes ( ) No ( )
Emergency contact: Name _____ Phone:_____
Does your emergency contact know that you're having an abortion? Yes ☐ No ☐
Preferred language: _____ Do you need assistance to fill out this form? Yes ☐ No ☐
If not English speaking, Interpreter's name _____
Pharmacy # _____
DRUG/FOOD/LATEX ALLERGIES: _____
CURRENT MEDICATIONS/ VITAMINS/ HERBAL SUPPLEMENTS: _____
FREQUENCY & LAST TAKEN: _____

Please check any of the following that apply:

OB History:
Complete below:

1. Total No. Pregnancies including current: _____ Living children: _____
Live births: _____ Miscarriages: _____ Abortions: _____at this facility? Y☐ N☐
Ectopic/tubal: ____ Other: _____
# of C-sections: _____ Last pregnancy when: _____
Problems with pregnancies: (high blood pressure, seizures, preeclampsia, gestational diabetes, birth defects) other: _____
2. First day of last period _____/_____/_____ Normal ☐ Abnormal ☐
3. Are your monthly cycles: ☐Regular ☐Irregular ☐Light ☐Heavy ☐Mild cramps ☐Severe cramps
4. Are you Rh neg: Y☐ N☐ Have you received Rhogam: Y☐ N☐

GYN History:

5. ☐ Have you ever had a pelvic exam/ Pap smear? Date of last exam _____
6. ☐ Abnormal Pap (date) _____
Treatment: Repeat pap (date) _____
Colpo/Cryo/LEEP/Laser
7. ☐ Breast disease or surgery/nipple discharge/leaking
8. ☐ Are you breast feeding/nursing
9. ☐ Vaginal infections/itching /burning /pain / bumps/ swelling/ sores
10. ☐ Sexually transmitted infections (Circle all that apply):
Herpes, HPV, Chlamydia, Gonorrhea, Trichomonas, Syphilis, HIV, Hepatitis B
11. ☐ Pelvic inflammatory disease (PID) Date_____
Treatment: _____
12. ☐ Uterine fibroids/ endometriosis
13. ☐ Cysts on ovaries
14. ☐ Genital circumcision
15. ☐ Bleeding and/or pain with sex

Contraception:

16. How have you prevented pregnancy in the past? _____
17. When, if ever, would you like to be pregnant again? _____

Social History: (The Feminist Women's Health Center is legally required to follow Georgia state law regarding the report of statutory rape and child abuse.)

	Y	N	
18.	☐	☐	Have you ever been forced to engage in sexual activity of any kind against your will?
19.	☐	☐	Are you now or have you ever been in an abusive relationship?
20.	☐	☐	Have you been treated for/ received counseling for emotional/mental illness?

Personal Medical History:

21. ☐☐ Hearing impaired. Do you know sign language Yes ( ) No ( )
22. ☐☐ Heart problems/palpitations/murmurs/surgery/valve replacement
23. ☐☐ High Blood Pressure/ medications:_____
24. ☐☐ Strokes/Blood Clots in head, heart, brain, lungs, legs/Head injury
25. ☐☐ High cholesterol/ blood fats
26. ☐☐ Diabetes/High Sugar: (insulin/pills/diet) Only with pregnancy
27. ☐☐ Bladder/Kidney problems/infections
28. ☐☐ Headaches/migraine, stress related or other
29. ☐☐ Seizures/epilepsy: Date of last seizure_____
30. ☐☐ Liver disease/Hepatitis
31. ☐☐ Stomach or bowel problems/gastritis/ ulcers/reflux disease/Colitis/IBS/Crohns
32. ☐☐ Gallbladder disease/Surgery
33. ☐☐ Thyroid conditions/ medications
34. ☐☐ Lung Problems/Disease/Asthma=(circle one) Childhood, Seasonal; Chronic
35. ☐☐ Do you have a history of drug or alcohol abuse?
36. ☐☐ Do you smoke? If yes, how many cigarettes per day?_____
37. ☐☐ Have you ever used crack, cocaine, pcp or another street drug in the past?
    Date of last use:_____
38. ☐☐ Anemia/Low Iron/Sickle Cell/Thalassemias/Blood diseases/Lupus
39. ☐☐ Cancer/ type:_____
40. ☐☐ Are you currently under care for a problem/illness by a health care professional? Explain _____
41. ☐☐ Have you ever been hospitalized for any reason except for childbirth?
    Explain _____
42. ☐☐ Received blood products? Year:_____ Reason Received:_____
43. ☐☐ Do you faint with needles/finger sticks/pap smears
44. ☐☐ Have you ever been put to sleep for any surgery? Did you have any problems-Y N
45. ☐☐ Do you have any piercings in your mouth or are you wearing glasses/contact lenses today?

Family History: **Adopted: Y ☐ N☐**

Fill in below: mom, dad, siblings, grandparents, aunts, and uncles

46. ☐ Diabetes _____
47. ☐ Problems with anesthesia_____
48. ☐ Heart attack before age 50 _____
49. ☐ High Blood Pressure _____
50. ☐ Cancer (breast, ovarian, uterus) _____
51. ☐ Strokes/Blood Clots in head, heart, brain, lungs, legs_____

- What other information or referrals may we provide for you?_____
- I affirm that I have been counseled about available options for birth control, including the benefits and risks of the method I have chosen: _____ (method(s))
- I affirm that all of the medical information stated above is true and that I have not had anything to eat, drink or gum since:_____

Client signature _____ Date/Time: _____ Updated: _____ Date/Time:_____

Counselor signature_____ Date/Time: _____ Updated: _____ Date/Time:_____

RN Pre-op Signature_____ Date/Time: _____ Updated: _____ Date?Time:_____

MD/NP Review _____ Date/Time:_____ Updated: _____ Date/Time: _____

CRNA Review_____ Date/Time:_____ Updated: _____ Date/Time: _____