Houston Women's Reproductive Services 5225 Katy Fwy. Suite 370 Houston. TX 77007

Patient Information/ Medical History

NAME:_____
FIRST LAST PREFERRED NAME

DATE OF BIRTH:_____AGE:_____ RACE:_____MARITAL STATUS: _____

ADDRESS:_____
STREET CITY STATE ZIP COUNTY

PHONE:_____OCCUPATION:_____EDUCATION:_____

EMERGENCY CONTACT:_____PHONE:_____RELATIONSHIP:_____

MENSTRUAL HISTORY

When did your last NORMAL period start?_____ How many days do you usually bleed? _____

BIRTH CONTROL HISTORY Check methods used

[ ] Birth Control Pills [ ] Condoms [ ] Depo-provera/shot [ ] Implant [ ] IUD [ ] Patch
[ ] Withdrawal [ ] Sponge [ ] Nuva Ring [ ] Diaphragm [ ] other_____

PREGNANCY HISTORY

Not counting this pregnancy, how many times have you been pregnant? _____ Currently breastfeeding: Yes/No

_____ _____ _____ _____ _____
Vaginal deliveries # C-Sections # Abortions # Miscarriages # Ectopic/Tubal Pregnancies

Complications:_____

GYNECOLOGY HISTORY

Date of last pap smear:_____ Normal: Yes No If no, explain: _____
Ovarian cysts, uterine fibroids: No Yes If yes, explain:_____

GENERAL MEDICAL

	No	Yes	If yes, please list/explain
Allergic to any medications?			
Do you take any medications?			
Have you ever been hospitalized?			
Have you had any surgeries?			
Any other significant health issues?			
Smoke cigarettes, use tobacco products			

Patient Information/ Medical History

NAME:_____DATE OF BIRTH:_____ Age:____

PERSONAL MEDICAL HISTORY - IF YOU HAVE EVER HAD, PLEASE CHECK ALL THAT APPLY

[ ] Anemia/Sickle Cell
[ ] Asthma, use an inhaler?
[ ] Bad chest pains or unusual shortness of breath
[ ] Bladder/kidney or urinary infection
[ ] Blood clots in your legs or lungs
[ ] Diabetes
[ ] Depression/suicidal tendencies
[ ] Eating disorder
[ ] Epilepsy, convulsions, seizures or fits
[ ] Heart disease, surgery or murmur
[ ] Hepatitis, type
[ ] High blood pressure
[ ] HIV positive or AIDS
[ ] Suicidal tendencies
[ ] Lupus/autoimmune disease
[ ] Migraine/medically diagnosed
[ ] Pelvic inflammatory disease (PID)
[ ] Psychiatric/ Nervous disorder
[ ] Sexually transmitted infection (Chlamydia, gonorrhea, herpes, HPV)
[ ] Thyroid disease
[ ] Tuberculosis
[ ] Vaginal infections (yeast, trichomonas)

Other health issues/concerns:_____

How long have you known about this pregnancy?_____
What were your first thoughts and feelings:_____
Have you discussed your decision with anyone? If so, whom?_____
Are they supportive? [ ]Yes [ ] No [ ] Somewhat
Any concerns or worries about the abortion you'd like to discuss [ ] No [ ] Yes _____

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This section is to be completed after talking with a staff member

The following information has been discussed with the patient:

__ Patient has considered all options: abortion, adoption, parenting
__ Patient has made her own decision, free of coercion and expressed confidence in that decision
__ How medical abortion works and any risks/complications
__ Answered questions about the procedure, medications, aftercare, need for follow up
__ Received aftercare instructions including name and phone number of hospital closest to patient's home

_____Hospital

__ Options for future birth control discussed. Pt chooses:_____

I have been informed of the above _____
Patient Signature

I discussed the above with the patient_____
Staff Signature

Notes:_____

_____

_____

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how your medical information can be used and disclosed and how you can get access to this information. Please review it carefully.

Houston Women's Reproductive Services is committed to protecting the privacy of your medical records and the confidentiality of your visit. Your records (chart) will not be released to anyone outside of this facility with out your written permission unless a release is required by law.

We will use your information for the following purposes:

1. Treatment- to determine your care and treatment
2. Payment- if using insurance we will release information necessary for billing
3. Regular Healthcare Operations- members of the staff may review your records as part of our quality assurance
4. Business Associates- if a billing/collection/funding service is used
5. The State of Texas requires reporting of statistical information regarding abortions, including age, race, marital status, and city of residence. We WILL NOT release your name, address, or any identifying information.

Disclosure required by law:

1. Food and Drug Administration (FDA)- if there were a drug/product recall or defect
2. Public Health- we may disclose your health information, to public health authorities in charge of controlling disease, injury or disability.
3. Law Enforcement- we may disclose health information in response to a valid subpoena.

YOUR HEALTH INFORMATION RIGHTS

Your health record is the physical property of the clinic but the information belongs to you and you have the right to the following:

1. Request a restriction on certain uses and disclosures of your information
2. Obtain a copy of the notice of information practices (this document)
3. Inspect a copy of your health records
4. Amend your health record as provided in 45 CFR 164.528
5. Obtain an accounting of disclosures of your health information

OUR RESPONSIBILITY

We are required to:

1. Maintain the privacy of your information
2. Provide you with a notice that explains our privacy practices
3. Abide by the terms of this notice
4. Notify you if we are unable to agree to a restriction that you request
5. Accommodate reasonable requests you may have to communicate health information by alternative means or locations.

We reserve the right to change practices and make new provisions.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

Please contact our privacy officer at the office. Complaints may also be filed with the U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

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Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare operations.

I understand that as part of my healthcare, this facility creates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as a:

- basis for planning my care and treatment
- means of communication among the health professionals who contribute to my care
- source of information for applying my diagnosis and surgical information to my bill
- means by which a third party payor (insurance) can verify that services billed were actually provided
- tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have read a copy of *Notice of Privacy Practices* that contains a more complete description of information uses and disclosures. I understand that I have the right to review the notice before signing this consent. I understand this facility can change their notice and practice and I may request a copy of any revised notice. I understand that I can restrict how my health information may be used. I understand that I can revoke this consent in writing, except to the extent that the organization has already taken.

Signature of Patient :_____Date:_____

Our Patients Have The Right To :

1 Make their own choices and self-determination.
2 Personal privacy and confidentiality of her choices and decisions.
3 Voluntary and informed consent as defined in Health and Safety Code (HSC) 171.012 without paying a fee for the informational materials.
4 A private opportunity to discuss medical information and ask questions.
5 View their own medical record, including the sonogram, if one has been performed, at any time as provided by law.
6 Access to care and treatment consistent with available resources and generally accepted standards regardless of race, creed and national origin
7 Ask questions after giving consent and to withdraw consent while still medically safe to do so.
8 Freedom from abuse, neglect or exploitation as those terms are defined in 1.204 of this title(relating to Abuse, Neglect or Exploitation Defined)
9 Review the department's informational materials as described in HSC 171.014 and 171.015.

Signature of Patient :_____Date:_____

OVER→

24 Hour Certification

Name:_____ Date_____

The following information was presented at least 24 hours prior to the abortion by the physician:

Patient initials:

____ the particular medical risks associated with the particular abortion procedure to be employed: including when medically accurate:
- ____ the risk of infection and hemorrhage;
- ____ the potential danger to subsequent pregnancy and of infertility; and
- ____ the possibility of increased risk of breast cancer following an induced abortion

____ the probable gestational age of the fetus at the time the abortion is to be performed

____ the medical risks associated with carrying the pregnancy to term.

Dr Sign:_____

The physician or the physician's agent has informed me that:

____ medical assistance benefits may be available for prenatal care, childbirth and neo-natal care;

____ the father is liable for assistance in the support of the child without regard to whether the father has offered to pay for the abortion;

____ public and private agencies provide pregnancy prevention, counseling and medical referrals for obtaining pregnancy prevention medications or devices.

____ I have the right to review the printed materials prepared by the Texas Department of Health entitled "A Woman's Right to Know" booklet and the resource directory which describes fetal development and list agencies that offer alternatives to abortion and that those materials must be given to me if I choose to view them.

____ "A Woman's Right to Know" booklet and resource directory are also available on an Internet website sponsored by the department.

Dr or Agent sign : _____

I made the following choice **(initial one):**

____ I declined the informational material

____ I chose to review "A Woman's Right to Know" materials on the website www.dshs.state.tx.us/wrtk

____ I requested and was provided a printed copy of "A Woman's Right to Know" booklet and resource directory

Patient signature:_____Date_____

TOLL-FREE TELEPHONE NUMBER 1-888-973-0022 You have the right to access certain information concerning this abortion facility by using the toll-free telephone number listed above. If you make a call to the number, your identity will remain anonymous.The toll-free telephone line can provide you with the following information:

- whether this abortion facility is licensed by Texas Health and Human Services Commission.;
- the date of the last inspection of this facility by the Texas Health and Human Services Commission and any violations of law or rules discovered during that inspection that may pose a health risk to you;
- any relevant fine, penalty, or judgment rendered against this facility or a doctor who provides services at this facility.

OVER →

Abortion And Sonogram Election

The information and printed materials described by sections 171.012(a)(1)-(3), Texas Health and Safety Code, have been provided and explained to me.

Initial each line:

____ I understand the nature and consequences of an abortion.

____ Texas law requires that I receive a sonogram prior to receiving an abortion.

_____ I understand that I have the option to view the sonogram images.

_____ I understand that I have the option to hear the heartbeat, (only if able to detect).

_____ I understand that I am required by law to hear an explanation of the sonogram images unless I certify in writing to one of the following:

____ I am pregnant as a result of a sexual assault, incest, or other violation of the Texas penal code that has been reported to law enforcement authorities or that has not been reported because I reasonably believe that doing so would put me at risk of retaliation resulting in serious bodily injury.

____ I am a minor and obtaining an abortion in accordance with judicial bypass procedures under chapter 33, texas family code.

____ my fetus has an irreversible medical condition or abnormality, as identified by reliable diagnostic procedures and documented in my medical file.

____ I am making this election of my own free will and without coercion.

_____ _____ _____

SIGNATURE PRINT NAME DATE

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For a woman who lives 100 miles or more from the nearest abortion provider that is a facility licensed under chapter 245 or a facility that performs more than 50 abortions in any 12-month period only: I certify that, because I currently live 100 miles or more from the nearest abortion provider that is a facility licensed under chapter 245 or a facility that performs more than 50 abortions in any 12-month period, I waive the requirement to wait 24 hours after the sonogram is performed before receiving the abortion procedure. My current residence is:

_____

City _____ State_____ Zip Code_____

_____ _____ _____

SIGNATURE PRINT NAME DATE