Sexually Transmitted Infection (STI) & Reproductive Health Clinic
Registration Forms

Patient Medical Information

Today's Date:		Is this the first time to our clinic? Yes or No		
First Name:		Last Name:		Middle Initial:
Date of Birth:		Phone Number: ______________________ Alternate Contact Number: ____________________		
Social Security Number:				
Address:		City:	State:	Zip code:
Marital Status:	Age:	Sex:		
Are you covered by Medicaid? Yes or No		Do you have private insurance? Yes or No Name of insurance: ____________________________________		
Why did you choose this clinic? ☐Family, Friend ☐ Advertisement ☐ Emergency Room, Urgent Care				

You must not eat, drink, chew gum, or smoke for at least 15 minutes before having HIV testing. *** ***You must not urinate until you have received your examination.	
When was the last time you urinated?	
Have you had a recent visit to the ER or Urgent Care? Yes or No Facility seen: _______________________________________ Date: ________________________	
Have you tested positive for a sexually transmitted infection within the past 30 days? Yes or No If yes, what STD were your treated for, and what medication did you receive? ____	
Have you had any recent laboratory work performed? Yes or No If yes, where did you have laboratory work performed? ____	
Date of Last Pap Test:	History of Abnormal Pap?
Where was the last pap test performed?	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Hancock Public Health. I understand that I am financially responsible for any balance. I also authorize Hancock Public Health to release any information to process my claims.

____ ___________________________

Patient Signature Date

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We will contact you by phone call and/or text message with appointment reminders. We will call you by phone with testing results. Please note that we will never leave a voicemail message or text message with abnormal lab results. In this case, if we reach you by voicemail, we will leave limited information with our business name and request a call back. Please indicate below your preferred method of contact. If you do not receive a phone call with in 10 days of having testing completed please call our office for results.

Forms of Contact: Please complete the forms of contact Hancock Public Health can utilize. If the phone number are not for you, please list first and last name along with the relationship of the person you authorize Hancock Public Health to disclose your health information.

Home: (__)___-_________ Self ___ Other: ____
Cell: (___)____-_________ Self ___ Other: ____
Work: (___)___-_________ Self ___ Other: ____
Mail/ Address: ____

Voicemail: Please check one of the following:
___ I authorize Hancock Public Health STI & Reproductive Health Clinic to leave voice messages on my voicemail message regarding appointment reminders and / or normal lab results.

___ I DO NOT authorized Hancock Public Health STI & Reproductive Health Clinic to leave voice messages on my voicemail regarding appointment reminders and / or normal lab results.

Text Message: Please Check one of the following:
___ I authorize Hancock Public Health STI & Reproductive Health Clinic to text the above listed cell phone number with appointment reminders.

___ I DO NOT authorized Hancock Public Health STI & Reproductive Health Clinic to text the above listed cell number with appointment reminders.

By Signing below you authorize Hancock Public Health STI & Reproductive Health Clinic to follow guidelines regarding our method of contact for you in regards to appointment reminders, testing results.

____ ___________________
(signature of client) (date)

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I hereby consent Hancock Public Health for treatment as necessary to provide reproductive health services and/ or family planning services including, education, prescription or non-prescriptive birth control, drugs or devices and medical service. I have been advised that periodical medical examination shall be required to continue to receive services. I consent to examination and laboratory testing as deemed necessary to monitor my reproductive health and/ or family planning services. These examinations include and are not limited to physical examination of genitals and pelvic examinations.

Family Planning Services are provided on a voluntary basis. Clients are not coerced to accept services or to use or not use any particular method of family planning. A client's acceptance of family planning services must not be a prerequisite to be eligible for, or receipt of, other services, assistance from, or participation in any other program that is offered. Clients are given the opportunity to participate in planning their own medical treatment. Clients are encouraged to voice any questions or concerns they may have.

Should any tests show abnormal results, Hancock Public Health staff will assist me in obtaining follow-up exams and any additional tests. If I refuse follow-up tests or treatment, Hancock Public Health staff will make efforts to ensure that I understand the implication and potential consequences of refusing or withdrawing consent for follow-up tests or treatment.

As a client of Hancock Public Health STI & Reproductive Health Clinic, I will receive services with the cost for such services depending on my insurance benefits and/ or income. The sliding fee scale will be utilized when my income warrants.

Signature ______________________________________ Date_________________

Printed Name _______________________________________ Date of Birth ________________

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I understand that as part of my health care with Hancock Public Health, records are created and maintained describing my physical health history, symptoms, examination, test results, diagnoses, treatment and 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 providers who contribute to my care
- Positive test of reportable sexually transmitted disease will be shared with public health agencies as required by law
- Means for verification of services for payment, and
- Tool for health care operations, such as assessing quality and reviewing competence for health professionals.

I understand that services are provided on a voluntary basis. I understand that as a condition of receiving care, Hancock Public Health may use or disclose my personally identified health information for treatment, payment, and health care operations purposes. These uses and disclosures are more fully explained in the *Notice of Privacy Practices* that has been provided to me, and which I have had the opportunity to review. I understand the privacy practices described in the *Notice of Privacy Practices* may change over time, and that I have a right to obtain any revised Privacy Notice by contacting Hancock Public Health, 2225 Keith Parkway Findlay Ohio 45840, to make a request. I understand that I have the right to request Hancock Public Health a restriction of how my health information is used or disclosed by completing a *Disclosure Restriction Request Form*. Hancock Public Health does not have to agree to my request for restriction, but if it does agree, it is bound to abide by the restriction as agreed.

I understand that I have the right to revoke/ withdraw this consent inwriting at any time. My revocation will be effective except to the extent that Hancock Public Health has acted in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

Signature:____ Date ______________
(expires in 1 year form this date)

Printed Name: ____ DOB______________

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Authorization for Release of Medical Record Information

Patient Name: ____ **Date of Birth:** _______________________

Address: ____ **City/State/Zip:** ______________________

Phone: ____

Above listed patient or parent/guardian authorizes the following agency to make record disclosure:

Agency Name: Hancock Public Health
Agency Address: 2225 Keith Parkway
Findlay, OH, 45840

Agency Phone: ______________________
Agency Fax: 419-424-7189

Dates of information to disclose:

☐ 2 years prior from last date seen.
☐ Dates other: _____________________

The purpose of disclosure is:

☐ Change of insurance or physician
☐ Continuation of Care
☐ Referral
☐ School/ Employer
☐ Other

Information to disclose: ____
____

This information may be disclosed and used by the following individual or organization:

Release To: ____

Address: ____

City, State, Zip: ____

Fax: ____ **Phone:** ____

☐ **Please mail records.** ☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provided my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ________________________________. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provide in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Hancock Public Health's privacy officer.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X ____ ____________________________

Signature of Patient/Parent/Guardian or Authorized Representative
(Guardian or Authorized Representative much attach document of such status.)

Date

____ ____________________________

Printed name of Authorized Representative

Relationship/Capacity to patient

____

Address and telephone number of authorized representative <u>if different than patient</u>.

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Please select one of the following options for payment of services:

____ **Choice #1:** I have **Medicaid** and authorize Hancock Public Health to submit services.

Primary Cardholder's Name: ______________________________ DOB: ______________
Consent for assignment of benefits: I authorize Hancock Public Health to bill my insurance and assign the payment of these benefits directly to Hancock Public Health. I assign Hancock Public Health all rights to benefits, insurance payments, insurance reimbursements, or other payments or judgements to which I may be entitled for services provided to me at Hancock Public Health.

Signature of Client: ________________________________ Date: _________

___ **Choice #2**: I have **private health insurance** and authorize Hancock Public Health to submit services.

Primary Cardholder's Name: ______________________________ DOB: ______________
Consent for assignment of benefits: I authorize Hancock Public Health to bill my insurance and assign the payment of these benefits directly to Hancock Public Health. I assign Hancock Public Health all rights to benefits, insurance payments, insurance reimbursements, or other payments or judgements to which I may be entitled for services provided to me at Hancock Public Health. I understand that I am responsible for any amount not paid by my health insurance or any other insurance plan or policy, including but not limited to, any deductibles, copays, and coinsurance amounts provided under any coverage source and charges for which there is no coverage source.

Signature of Client: ________________________________ Date: _________

___ **Choice #3**: I have no insurance, or I am under-insured. Cost for services provided will depend on my income. The sliding scale will be utilized when my income warrants.

___ I DO NOT have private insurance or Medicaid coverage for myself.
___ I have Insurance but services / vaccines are not covered by the insurance.
___ Hancock Public Health is a non-participating provider with my health insurance.

Signature of Client: ________________________________ Date: _________

___ **Choice #4:** I have health insurance but wish to remain anonymous and self-pay for all services and fees. The cost for services will depend on my income. The sliding scale will be utilized when my income warrants.

___ I DO NOT give permission for my insurance agency to be billed for services and wish to remain anonymous.

Signature of Client: ________________________________ Date: _________

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Name :____ Date of Birth: _______________
Todays Date: ______________
Please List any hospitalizations or surgeries: ____
____

Family History: Do your parents, grandparents or siblings have any of the following?

___ Bleeding Disorders ☐ Don't know ☐ Yes ☐ No
___ Death before age 50 ☐ Don't know ☐ Yes ☐ No
___ Depression ☐ Don't know ☐ Yes ☐ No
___ Genetic Disorders ☐ Don't know ☐ Yes ☐ No
___ Glaucoma ☐ Don't know ☐ Yes ☐ No
___ High Blood Pressure ☐ Don't know ☐ Yes ☐ No
___ Mental Illness ☐ Don't know ☐ Yes ☐ No
___ Respiratory Disease ☐ Don't know ☐ Yes ☐ No
___ Cancer ☐ Don't know ☐ Yes ☐ No
___ Diabetes ☐ Don't know ☐ Yes ☐ No
___ Epilepsy/ seizure ☐ Don't know ☐ Yes ☐ No
___ Heart Attack ☐ Don't know ☐ Yes ☐ No
___ Kidney Disease ☐ Don't know ☐ Yes ☐ No
___ Liver / GI Disease ☐ Don't know ☐ Yes ☐ No
___ Osteoporosis ☐ Don't know ☐ Yes ☐ No
___ Stroke ☐ Don't know ☐ Yes ☐ No
___ Pregnancy / Post Partum Depression ☐ Don't know ☐ Yes ☐ No
___ Did your mother take DES hormones to prevent a miscarriage? ☐ Don't know ☐ Yes ☐ No
___ I was adopted and do not know any biological family history.
___ I have reviewed all family history and none apply.

Personal Review of systems: Please Indicate if you are currently having any of the following symptoms.

Constitutional
___ Fever/ chills. Sweats
___ Fatigue/ weakness
___ Unexplained weight loss/ gain
___ Excessive thirst or urination

Ears/ Eyes/ Nose/ Throat/ Mouth
___ Difficulty hearing / ringing in the ears
___ Change in vision
___ Problems with teeth/ gums
___ Hay fever/ allergies
___ Thyroid problems

Cardiovascular
___ Chest pain/ discomfort
___ Leg pain with exercise
___ Palpitations
___ Heart Disease
___ High Blood Pressure

Chest (Breast)
___ Breast lump/ discharge

Blood / Lymphatic
___ Unexplained lumps
___ Easy Bruising
___ Anemia

Respiratory
___ Asthma
___ Cough/ Wheezing
___ Difficulty breathing

Gastrointestinal
___ Abdominal Pain
___ Blood In stool
___ Nausea/ vomiting
___ Diarrhea
___ Gallbladder disease
___ Hepatitis
___ Diabetes
___Stomach Ulcers

Genitourinary
___ Nighttime urination
___ Leaking urine
___ Discharge from penis/ vagina
___ Unusual vaginal bleeding
___ Sexual Function Problems

Genetic Disorder
___ Please Describe: _________________________________

Musculoskeletal
___ Muscle/ joint pain

Skin
___ Rash
___ Mole Changes

Neurological
___ Headaches
___ Dizziness
___ Numbness
___ Memory Loss
___ Seizure disorder
___ Loss of coordination

Psychiatric
___ Anxiety/ Stress
___ Anorexia
___ Depression
___ Problems with sleep

All the above is accurate and complete to the best of my knowledge.
___________________________________ (patient)

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Name ____________________________ DOB _______________________ M_____ F______

1. Are you allowed to come and go as you please in your home or workplace? Y N
2. In the last year, have you felt isolated, trapped, or like you were walking on eggshells in an in an intimate relationship? Y N
3. In the last year, has anyone controlled where you go, who you talk to or how you spend money? Y N
4. In the last year, has your partner ever intimidated you or made you feel Scared? (For example, punching you into a corner or punching a wall) Y N
5. In the past year, has anyone hit, kicked, punched, or otherwise hurt you? Y N
6. In the past year, has anyone pressure or forced you to do something sexual that you didn't want to do? Y N
7. Do you change what you say or do to avoid disagreeing with your partner to avoid negative consequences? Y N
8. Does anyone restrict your communication with others? Y N
9. Does anyone make decisions about your birth control and /or use of sexual protection without your consent? Y N
10. Has your partner ever tried to force or pressure you to become pregnant when you didn't want to be? Y N
11. Has anyone made you take drugs, alcohol, or medication you didn't want? Y N
12. In the last year, has anyone restricted your access to medical care? Y N

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Hancock Public Health Sexually Transmitted & Reproductive Health Clinic

Income Assessment

The follow is a complete report of all income in my household for most current 30-day period.

Relationship of household member (Ex. Mom, Aunt, brother)	Source of Income	Amount of Income
1.		
2.		
3.		
4.		
5.		

_____ I am under 18 years old and requesting confidential services.

_____ I am under 18 years old and not requesting confidential services.

If you cannot provide written proof of income at this visit, we will accept your verbal assurance of your income at this time. No one is denied services due to inability to pay.

Signature ____

Date __________________________________

Fee Category ___________________________

Cost of Service _________________________

Your Payment ___________________________