HCCMS
Family Health Services
Helping Communities Connect Multiple Services

Serving Audubon, Buena Vista, Calhoun, Carroll, Crawford, Greene, Guthrie, Pocahontas, and Sac Counties
Child/Adolescent Health & Family Planning
105 N. Main Street Denison, IA 51442
Phone: 712-263-3303 Fax: 712-263-4033

Welcome to HCCMS Family Health Services Family Planning Program!

We are happy that you chose us to be your provider!

We need the following items to get you set up in our system:

- ☐ A photo identification (ID) such as a driver's license, student ID, or permanent resident card
- ☐ Your Social Security number (card is preferred) if you have one
- ☐ Your current insurance and/or Medicaid card

You can apply for family planning insurance (SFPP) that will pay for your services, copayments and some items not covered by insurance. If you want to apply, you will need to provide the following:

- ☐ Your most recent 4 weeks (1 month) pay stubs OR the previous year's tax return (for you and your spouse)

If you do not have insurance or qualify for SFPP, you MIGHT qualify for reduced cost or no cost (free) services. To apply for reduced cost or no cost (free) services, we need the following information:

- ☐ Your most recent 4 weeks (1 month) pay stubs OR the previous year's tax return (for you and your spouse/partner)

If you do not have insurance or SFPP, you are responsible for paying full fee for your services until a discount determination is made.

<u>All paperwork must be sent to our office by mail, fax, or email prior to your appointment.</u> Please call our office at 712.263.3303 with any questions or concerns.

- ◆ Address: 105 N Main St, Denison, IA 51442
- ◆ Fax: 712.263.4033
- ◆ Email: aeggers@crawfordcounty.iowa.gov

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Consent for Family Planning Services

I understand that my use of family planning services is voluntary and that I can stop receiving services at any time. I understand that I am not required to use family planning services or use any certain family planning method.

I understand that HCCMS Family Health Services (HCCMS) does not require me to use family planning to receive, or be eligible for, any other services, or assistance from any other program they offer.

I have been informed that HCCMS provides services that are client-centered, culturally and linguistically appropriate, inclusive, and trauma-informed; that protect my dignity; and that ensure equitable and quality service delivery consistent with nationally recognized standards of care.

I have been informed that HCCMS must provide services without regard to religion, race, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies, or marital status.

I have been informed that HCCMS must ensure my confidentiality and that information obtained about me in the process of receiving family planning services may not be shared without my written consent—except as required by law or as may be necessary to provide me with services and with all appropriate safeguards for maintaining my confidentiality.

I understand that if I have a reportable disease, HCCMS is required to report to the State of Iowa Public Health.

Via this consent, I approve the release of data and information to the Iowa Department of Health and Human Services, the Office of Population Affairs, and their agents to improve quality, access, and equity in Title X family planning services. This will not include any direct identifiers, such as your name and address.

I understand that HCCMS may be required to share my information to comply with laws requiring notification or reporting of child abuse, child molestation, sexual abuse, rape, incest, intimate partner violence, human trafficking, or other similar reporting laws.

I have been informed that HCCMS may share my information to obtain payment from a third party, such as insurance company or Medicaid, that is authorized or required to pay for my services.

If I am not the policy holder, I understand that there is potential for disclosure of my confidential health information with the policy holder. I understand that I can request that services be provided confidentially and without payment from a third party, to avoid the disclosure of my confidential health information.

I understand that HCCMS may not require the consent of my parent or guardian for me to get family planning services. I also understand that HCCMS may not notify my parent or guardian before or after I have requested and/or received services.

I understand that if I consent to family participation [participation of my parent(s) or guardian(s)] when I receive family planning services, I have the right to revoke that consent at any time and to request that services be provided confidentially.

I understand that family planning services may include:

- Reproductive health counseling on birth control, getting pregnant, healthy pregnancies, and other subjects as needed;
- Providing a birth control method;
- A provider visit for a prescription and maybe a physical exam;
- Testing and/or treatment for sexually transmitted infections (STIs);
- Testing for cervical cancer, pregnancy and/or other health problems; and
- Referrals to other services, if needed.

I understand that all services will be explained and I can ask questions.

I understand these services do not include 24-hour care, and in case of a medical emergency, I will need to go an emergency room and pay its costs.

I understand that the services I receive, and my medical records are private, except:

- If a judge issues a subpoena for my records. HCCMS is required by law to give the records to the court.
- If I have a reportable disease, HCCMS is required to report it to the Iowa Department of Health and Human Services.
- If HCCMS staff learns of physical and/or sexual abuse, they are required to report it to the Iowa Department of Health and Human Services and/or law enforcement.

I understand that if I get reproductive health services here, I can still apply for or get services from other programs. If I get care from other programs, I can still get services at HCCMS.

I, (print my name) _____, have read and understand the above information, and consent to receive reproductive health services from HCCMS Family Health Services.

_____ _____

Client Signature Date

Records Release for Claims Payment

I understand that I am responsible for paying for all services received. I understand that discounts apply to family planning services and birth control related services ONLY. I agree to pay for any charges not covered by insurance, Medicaid, or sliding fee scale. I understand that services will not be denied for inability to pay.

I authorize the release of medical record information or excerpts thereof to any insurance company or third-party payer for utilization management audit purposes and/or the purposes of verifying the services provided and obtaining payment on the account. I understand execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization.

I assign all my rights to receive all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to HCCMS, and direct that payment of proceeds be made to HCCMS.

_____ _____

Client Signature Date

These consents are valid for one year from the signature date unless revoked by me in writing and may not be revoked for services rendered prior to my notice of revocation. A photocopy of this consent form will be considered as valid as the original.

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Client Information Form Information about YOU	Date:

DOB:

First Name Middle Name Last Name

Home Address City State Zip County

Mailing address same as above: ☐ Yes If no, mailing address: _____

Social Security Number Home phone number Cell phone number

Preferred method of contact: ☐ Home phone ☐ Cell phone ☐ Email

Email address

Are you a student? ☐ No ☐ Yes ☐ High School ☐ College

Race (select all that apply):
☐ White ☐ American Indian/Alaskan Native ☐ Unknown
☐ Asian ☐ Black/African American ☐ Choose not to disclose
☐ Native Hawaiian/Pacific Islander

Marital status:
☐ Single ☐ Partner/Significant Other ☐ Divorced
☐ Married ☐ Separated ☐ Widowed

Sexual Orientation:
☐ Bisexual ☐ Lesbian, Gay, or Homosexual
☐ Straight or Heterosexual ☐ Other, something else
☐ Unknown ☐ Choose not to disclose

Gender assigned at birth: ☐ Male ☐ Female

Gender Identity:
☐ Male ☐ Female-to-Male/Transgender Male/Trans Male
☐ Female ☐ Male-to-Female/Transgender Female/Trans Woman
☐ Other ☐ Identify as neither male or female
☐ Unknown ☐ Choose not to disclose

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Is English your primary language? ☐ Yes ☐ No

If NO, what is your primary language? _____ Do you need an interpreter? ☐ Yes ☐ No

_____ # of people living in your home (include yourself, your spouse/significant other/partner, children high school age and younger)

_____ Your monthly income (before taxes)

_____ Spouse/Significant other/partner monthly income (before taxes)

_____ I choose NOT to provide income information and understand that I will be billed for services without any discounts.
Initials

Is it OK for us to send you mail (like insurance information, test results, etc.)? ☐ No ☐ Yes

If no, please explain:

Insurance Coverage:
☐ Self-pay ☐ Public health program ☐ Charity program
☐ Health spending account ☐ Womens' cancer detection program ☐ Military health program
☐ Public healthcare ☐ Health insurance plan policy ☐ Veteran health program
☐ Managed care policy ☐ Indigenous peoples health program

Payer for visit:
☐ None (no charge for services) ☐ Medicaid (MCO) ☐ Worker's compensation
☐ Medicare (traditional fee for service) ☐ Other government (Tricare, VA, etc.) ☐ Self-pay
☐ Medicare (HMO/managed care) ☐ Private insurance/Medigap ☐ Other: _____
☐ Medicaid (Traditional fee for service) ☐ Private HMO/managed care ☐ Unknown
☐ State Family Planning Program

Name: Date of Birth:

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Family Planning Health History

Date:

Who is your doctor?	Last visit date and reason:
Who is your dentist?	Last visit date and reason:
What pharmacy do you use?	City:
List any medicines or vitamins taken:	

Allergies

Medications:	Foods:	Environment:
What happens when you are exposed to this?	What happens when you are exposed to this?	What happens when you are exposed to this?

Social History

Men: In the past year, have you had 5 or more alcoholic drinks in a day? ☐ **None** ☐ **1 or more**

Women: In the past year, have you had 4 or more alcoholic drinks in a day? ☐ **None** ☐ **1 or more**

How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons? ☐ **None** ☐ **1 or more**

What type of tobacco/nicotine products do you use? ☐ **None** ☐ **Cigarettes/Cigars** ☐ **Chew** ☐ **Vaping**

How often do you use tobacco/nicotine products? ☐ **Never** ☐ **Less than daily** ☐ **Daily**

Have you tried to quit using tobacco/nicotine products in the past 12 months? ☐ **Yes** ☐ **No**

Do you want to quit using tobacco/nicotine products now? ☐ **Yes** ☐ **No**

What types of caffeine products do you use? ☐ **Soda/Pop** ☐ **Coffee** ☐ **Energy Drinks** **Other:** ☐

How much caffeine do you use each day? _____ **# 20 oz. sodas/pops each day**

# of cups of coffee each day **# energy drinks each day** **Other:**

Do you feel safe in your relationship? ☐ **Yes** ☐ **No**

In the past year have you been hit, slapped, kicked, or physically hurt by someone? ☐ **Yes** ☐ **No**

Has anyone forced you to do sexual activities that made you feel uncomfortable? ☐ **Yes** ☐ **No**

How often do you use your seatbelt in a vehicle? ☐ **Always** ☐ **Sometimes** ☐ **Never**

In the last 2 weeks, have you felt little interest or pleasure in doing things? ☐ **Yes** ☐ **No**

In the last 2 weeks, have you felt down, depressed, or hopeless? ☐ **Yes** ☐ **No**

In the last 2 weeks, how often have you been bothered by the following problems:

Feeling nervous, anxious, or on edge	Not at all ☐	Several days ☐	More than half the days ☐	Nearly every day ☐
Not being able to stop or control worrying	Not at all ☐	Several days ☐	More than half the days ☐	Nearly every day ☐
Worrying too much about different things	Not at all ☐	Several days ☐	More than half the days ☐	Nearly every day ☐
Trouble relaxing	Not at all ☐	Several days ☐	More than half the days ☐	Nearly every day ☐
Being so restless that it is hard to sit still	Not at all ☐	Several days ☐	More than half the days ☐	Nearly every day ☐
Becoming easily annoyed or irritable	Not at all ☐	Several days ☐	More than half the days ☐	Nearly every day ☐
Feeling afraid, like something bad is going to happen	Not at all ☐	Several days ☐	More than half the days ☐	Nearly every day ☐

Name: Date of Birth:

Reproductive History

Age at first period:	First day of last period:	Age at menopause:
Periods are: ☐ Regular ☐ Irregular	Periods last:	days
Interval between periods: ☐ 28 days ☐ 28-32 days		☐ more than 32 days
Flow is: ☐ Light ☐ Moderate ☐ Heavy		
Cramps with your period? ☐**Yes** ☐**No**	Do you have premenstrual symptoms (PMS)? ☐ **Yes**	☐**No**
If you get PMS what symptoms do you get? Acne☐Back pain☐Breast pain☐HA☐Irritable☐Cramping ☐		
Have you ever been pregnant/fathered a pregnancy? ☐**Yes** ☐ **No**		# of pregnancies:
Date of last delivery:	Are you currently breastfeeding? ☐**Yes**	☐ **No**
# of live births: ☐ Vaginal ☐ C-Section	# of miscarriages:	# of abortions:
Never had a pap: Yes☐No☐	Date of last pap?	

Reproductive Life Plan

Are you currently trying to have a child? ☐**Yes** ☐**No** Do you want to have a child/more children some day? ☐**Yes** ☐**No**

When do you want to have a child/more children?

☐ **Never** ☐ **Next 12 months** ☐**1-3 years** ☐ **3-5 years** ☐**5-10 years** ☐**Longer**

Are you worried about getting pregnant or getting your partner pregnant now? ☐**Yes** ☐ **No**

What could you do to prevent pregnancy if you don't want to have a child?

Have you talked to your partner about your pregnancy plans? ☐**Yes** ☐**No**

Do you want more information about planning for or preventing pregnancy? ☐**Yes** ☐ **No**

Patient Medical History

Hospitalizations/surgeries and dates:

Serious injuries and/or accidents and dates:

What are your current/recent medical concerns?

Please mark (☒) problems you have now or have had:

☐	Abdominal pain	☐	Hemophilia
☐	ADD/ADHD	☐	Hepatitis
☐	Anemia /Sickle cell	☐	Heart attack/Heart Disease/Chest Pain
☐	Anxiety	☐	High blood pressure/Stroke
☐	Asthma /Lung disease	☐	HPV
☐	Back pain	☐	Kidney disease
☐	Bipolar	☐	Mental Health diagnosis
☐	Birth defects	☐	Neurologic disorders
☐	Bladder infections (chronic)/Bladder disease	☐	Vision problems (other than corrective lenses)
☐	Blood transfusion	☐	Sexually transmitted infections
☐	Breast disease/lump/nipple discharge	☐	Thyroid problems
☐	Blood clots in legs or lungs	☐	Tuberculosis
☐	Cancer	☐	Valve replacement
☐	Colposcopy/LEEP	☐	Painful ejaculation
☐	Depression	☐	Pain or bleeding during /after sex
☐	Diabetes/Pre-diabetes	☐	Vaginal drainage/odor/itching/irritation
☐	Endometriosis/Ovarian Cysts	☐	Vaginal infection/Pelvic inflammatory disease
☐	Epilepsy/Seizures	☐	Drainage/itching/irritation/sores on the penis
☐	Headaches /Migraines	☐	Testicular lump/scrotal lump

Name: Date of Birth:

Family Medical History

Please place a check (✓) in the box next to each condition as it applies to your family:

☐ **Adopted-family history unknown**	Mom	Dad	Sister	Brother	Grandma P-Paternal M-Maternal	Grandpa P-Paternal M-Maternal	Aunt P-Paternal M-Maternal	Uncle P-Paternal M-Maternal
Anemia/Blood disorder	☐	☐	☐	☐	☐	☐	☐	☐
Asthma/Lung disease	☐	☐	☐	☐	☐	☐	☐	☐
Birth defects	☐	☐	☐	☐	☐	☐	☐	☐
Bladder disease/Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Pre-diabetes/Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Headaches/Migraines	☐	☐	☐	☐	☐	☐	☐	☐
Heart attack/Heart disease	☐	☐	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐	☐	☐
High blood pressure/Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Neurologic disorders	☐	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐

Sexual History/Risk Assessment

Are you currently having sex? ☐**Yes** ☐**No** If not, have you ever had sex before? ☐**Yes** ☐**No**

Age in which you had sex for the first time?

How many sex partners have you had: In the last 3 months? In the last 12 months? In a lifetime?

Are your sex partners: ☐**Men** ☐**Women** ☐**Both** Do you use condoms when you have sex? ☐**Yes** ☐**No**

Have you ever had an STD? ☐Yes ☐No When? How was it treated?

Has your current partner or any former partners ever had or been treated for an STD? ☐**Yes** ☐**No**

Have you had any symptoms that came back? ☐**Yes** ☐**No** Would you like to be tested for STDs or HIV? ☐**Yes** ☐**No**

What concerns or questions regarding your sexual health or sexual practices would you like to discuss?

Contraceptive History | Please mark (x) methods you have used:

☐ None ☐ Abstinence ☐ Condoms-Female ☐ Condoms-Male ☐ Implant ☐ Injection ☐ IUD/IUS ☐ Patch ☐ Pills
☐ Ring ☐ Sterilization ☐ Withdrawal ☐ Diaphram ☐ Natural Family Planning ☐ Sponge ☐ Other:

Describe any problems you've had with birth control: ☐ None

Have you ever had abnormal vaginal bleeding? ☐**Yes** ☐**No**

My current method is: | I want to continue this method: ☐**Yes** ☐**No**

I want to change my method to:

Other:

What other things should we discuss to ensure your overall good health?