



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.

All paperwork must be sent to our office by mail, fax, or email prior to your appointment. 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: aeggert@crawfordcounty.iowa.gov

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.

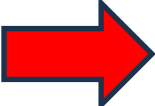
I understand that all services will be explained and I can ask questions.

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.

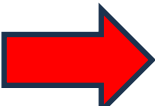
I understand that the services I receive, and my medical records are private, except:

- 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

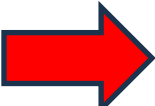
Date

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.



Client Information Form	Date: _____
Information about YOU	

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

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

Name:

Date of Birth:



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:	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular	Periods last: days
Interval between periods:	<input type="checkbox"/> 28 days <input type="checkbox"/> 28-32 days	<input type="checkbox"/> more than 32 days
Flow is:	<input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> 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:	<input type="checkbox"/> Vaginal <input type="checkbox"/> 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:**

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

<input type="checkbox"/> 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 Diaphragm 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?
