LOVERING HEALTH CENTER
Sexual Health, Choice & You

General Consent Form

I am asking for medical care and treatment at this facility and agree to accept services which may diagnose my medical condition, procedures that treat my medical condition and other necessary medical care.

I understand that my agreement to accept these services is called a General Consent and that it includes any routine procedure(s) or treatment(s) such as blood drawing, physical examination, administration of medication, use of local anesthesia and other procedures.

I do acknowledge that different declarations may be needed for some specific diagnostic and surgical procedures as well as contraception.

I understand that STI test results may be released to the New Hampshire Division of Public Health Services.

I understand that these services will be provided to me by licensed nurse practitioners, physicians, registered nurses and other licensed healthcare providers.

In the case of a medical emergency or hospital transfer, I authorize the Joan G. Lovering Health Center to obtain or release any medical records to any hospital or qualified physician relating to my scheduled visit that may be necessary. This includes the release of records and lab reports verbally, via fax and/or in writing to identified physician.

I authorize the Joan G. Lovering Health Center to utilize my medical information or to release all or part of my medical information to other healthcare providers consulted by my healthcare provider or the clinic, as may be necessary.

I understand that my agreement to accept these services will remain in effect unless I say that I no longer want these services, procedures and or treatments.

I have read the Patient Bill of Rights (RSA 151:21) and have been fully informed of and understand my rights and responsibilities as a client of the Joan G. Lovering Health Center.

I understand I must provide a picture ID and a copy will be kept in my chart. I also will need to show a picture ID for release of medical records.

I would like a copy of the HIPAA Privacy Practices ☐ **YES** ☐ **NO**

Patient Name (Print) D.O.B.

Patient Signature Today's Date

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The Joan G. Lovering Health Center Financial Policies

- We accept cash, money order, Visa/MasterCard, or Discover Card as payment.
- Patients are financially responsible for all services actually provided, regardless of whether they received all the services anticipated. At a minimum, all patients will be charged for an office visit.
- Patients are responsible for balances remaining following claim processing.
- All lab work, with minor exceptions. Charges for lab work provided for patients paying out-of-pocket or that are not covered by a patient's insurance company are the patient's financial responsibility. The lab will bill for all lab related services they perform and these fees are separate from Health Center fees. Patients can opt to pay for any tests at the time of their visit. This may result in a less expensive fee to the patient.
- We reserve the right to charge patients a missed appointment fee each time they do not show for their scheduled appointment or if an appointment is cancelled with less than 24 business hours' notice.

Insurance Patients Only

- All co-payments, co-insurance, and deductibles are due at the time of service.
- In order to check benefits and eligibility we must have the most current insurance information 24 business hours before an appointment.
- The benefit quotes we receive from an insurance company are NOT a guarantee of payment. Benefits are subject to the terms, limitations and exclusions of a specific policy.
- If an insurance company requires a referral to be seen by our practice, we must have the appropriate referral at the time of service. If the referral is not provided to us on the day of service, patients will be responsible for the full cost of the visit.
- **Patients are financially responsible for all balances remaining following claim processing, including:**
  - **Charges that are denied because services are either non-covered or excluded from a policy.**
  - **Charges that are denied because services were rendered after the termination date of a policy.**
  - **Claims that have a patient balance remaining after the insurance company has paid the allowable benefit for services rendered. You will be billed for the patient responsibility amount.**

I authorize payment of medical benefits to the named provider –Joan G. Lovering Health Center of Portsmouth, Inc. d/b/a Joan G. Lovering Health Center – for professional services rendered.

_____ _____
Patient Signature **Date**

Please initial the necessary authorizations below:
_____ I authorize the release of medical information and records necessary to process my insurance claim(s).
_____ I authorize the release of insurance information and diagnosis codes to any lab used for my care.

Patient Consent - Please read and sign the consent below:
I have read, understood, and agree to comply with financial policies put forth by The Joan G. Lovering Health Center and have had my questions answered regarding these policies. I understand that I can request a copy of these policies for my personal records at any time.

_____ _____ _____
Patient Signature **Patient Name (Print)** **Date**

_____ _____ _____
Staff Signature **Staff Name** **Date**

Revised 10/2017

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Patient Statistics Information Sheet: Thank you for providing us with this information. The information contained on this form will remain confidential and is only used to help us report to our funders and to design our healthcare services.

* required field

*Name: _____ *DOB: _____

*Gender Assigned at Birth: MALE / FEMALE Gender Identity: _____

*Marital Status: _____Married _____Divorced _____ Single

Email Address _____ Would you like to opt in to our email updates (Yes / No)

*Race:

_____ White/Caucasian

_____ African American

_____ Asian

_____American Indian / Alaskan Native

_____Native Hawaiian / Pacific Islander

_____ Rather not say

*Hispanic/Latino:

_____Yes

_____No

_____Rather not say

*Do you consider yourself English proficient?

_____ Yes _____No

Primary Language: _____

Insurance:

_____ Anthem

_____ Blue Cross & Blue Shield

_____ Cigna

_____ Harvard Pilgrim

_____ NH Medicaid

_____ United Health Care

_____ Maine Community Health Options

_____ Minuteman

_____Aetna

_____NH Healthy Kids

_____Tufts

_____ Wellsense

_____ NH Healthy Families

_____Maine Care

_____Other (please specify)

Contraception Normally Used:

_____Birth Control Pills _____IUD _____Nexplanon _____Nuva Ring

_____ Depo Shot _____Male Condom _____Female Condom _____Abstinence

_____Emergency Contraception _____Vasectomy/Tubal Ligation _____No Method

Due to non-profit reporting requirements for the State of NH, we are required to gather financial information from our patients:

***Household Size** (# of persons you are financially responsible for): _____

***Monthly gross income** (before taxes); If receiving unemployment assistance or are financially supported by a spouse or family member please include in amount: _____

Name: _____

Date of Birth: _____/_____/_____

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PROCEDURE HEALTH HISTORY

Reason for visit: _____

What pronouns do you use? (example: he/she/they)

Medications: *Are you currently taking any prescription and/or over-the-counter medications?* if yes, list:

Allergies: _____

Personal Medical History *(Check YES for those that pertain to you)*

YES	NO		YES	NO	
		Anemia			Breast mass or breast cancer
		Asthma, Last attack:			Breast biopsy or breast surgery (breast hyperplasia or carcinoma in situ)
		Abnormality or trauma to scrotum			Radiation therapy
		High blood pressure			Lupus or Rheumatoid Arthritis
		Stroke			Liver disease/hepatitis/cirrhosis
		Heart disease/attack/irregular heartbeat			Gall bladder disease
		Blood clots in legs or lungs			Adrenal failure
		Bleeding problems or a clotting disorder			Thyroid disease
		Headaches/Migraine headaches			Depression/Anxiety/Mood disorder
		Seizures/Epilepsy			HIV/AIDS
		Diabetes			Kidney disease
		Osteoporosis			Endometriosis
		Ovarian cysts			*Porphyria* (inherited disease that causes a buildup of chemicals)
		History of STI (circle which ones) Chlamydia Gonorrhea Herpes HIV Syphilis Warts/HPV			**History of surgery of cervix:**

Surgical History: *Have you ever had surgery*? If yes, please list surgery and date:

Have you had the following illnesses or immunizations? *(check all that apply)*

Measles, Mumps, Rubella_____ Chicken pox (Varicella) _____ Hepatitis A _____ Hepatitis B ____ HPV_____ Tetanus_____

Family Medical History: *Has a blood relative (parent, sibling, grandparent) had any of the follwing?:*

YES	NO		**Relative** (and whether mother/fath
		Cancer (uterine, ovarian, breast, colon, other)	
		Genetic abnormalities	
		High blood pressure/ heart disease/ heart attack	
		Stroke	
		Blood clots in legs or lungs	
		Bleeding disorder	
		Osteoporosis	

Menstrual History: First day of last menstrual period: _____/_____/_____ Age at first menses: _____

Are your menses regular/monthly? **Y / N** Flow (circle one): Light/Moderate/Heavy # days: _____

Have you experienced menopause? **Y / N** Vaginal bleeding? **Y / N** Hot flashes? **Y / N** Vaginal dryness? **Y / N**

Name: _____ Date of Birth: _____/_____/_____

Gynecologic History: *(if that pertains to you)*

YES	NO	
		Have you been pregnant before? **Y / N** total # pregnancies_____ # Vaginal births _____ # C-sections _____ # Abortions _____ # Miscarriages _____ # Still Births _____ # Ectopic _____ Premature deliveries _____ Any pregnancy related complications? **Y / N** Are you planning to become pregnant in the next 12 months? **Y / N** Problems/concerns with infertility?
		Were any of your children born premature (before 37 weeks)?
		Have you ever been diagnosed with a molar pregnancy or abnormally growing pregnancy tissue?
		Are you currently breastfeeding?
		Have you ever had a Pap test? if yes, approximate month/year: Was it normal? (circle one) Yes No Unsure
		Do you have uterine fibroids or other uterine abnormalities?
		Have you ever had surgery on your uterus, fallopian tubes or ovaries?
		Have you ever been diagnosed with pelvic inflammatory disease (PID)?
		Have you ever had surgery on your cervix, colposcopy, cryotherapy or LEEP?
		Do you leak urine when you cough, laugh, lift something or sneeze
		Do you ever experience a strong urge to urinate if not making it to the bathroom on time?

Contraceptive History: Please circle all methods you are currently using or have used in the past:

Abstinence	Condoms	Emergency contraception (Morning after pill/Plan B)	Diaphragm/Cervical cap/Sponge/Spermicide	Fertility Awareness Method (Rhythm)
Implant (Nexplanon)	Injection (Depo Shot)	Hormonal IUD (Mirena, Liletta, Kyleena, or Skyla)	Copper IUD (Paragard)	Patch
Pill	Ring (NuvaRing)	Same sex partner	Tubal Sterilization	Vasectomy
Withdrawal (Pull Out)	Other:			

Any problems with any of the above methods used? **Y / N**
If so, what kind?_____

Birth Control/Contraceptive plans: Please circle the method you would like prescribed/inserted after your procedure:

Copper IUD (Paragard)	Pill	Injection (Depo Shot)
Hormonal IUD (Mirena, Liletta, Kyleena, or Skyla)	Patch	Nothing, my partner plans for vasectomy
Implant (Nexplanon)	Ring (NuvaRing)	Nothing, I have a prescription from an outside provider
Other:		

Social History

Do you smoke? **Y / N** How many each day? ____ Smoked how many years? _____
Do you use alcohol? **Y / N** How much? # ____/ day or # ____/ week
Any recreational drug use or use of a prescription medication for nonmedical reasons? **Y / N**
Do you or your partners have a history of injectable drug use? **Y / N**
Do you have problems falling asleep or staying asleep? **Y / N**

During the past month, have you often been bothered by feeling down, depressed or hopeless? **Y / N**
During the past month, have you often been bothered by little interest or pleasure in doing things? **Y / N**
Are you currently or have you ever experienced emotional abuse, domestic violence, or sexual assault? **Y / N**
Has anyone forced you to have sexual activities that made you feel uncomfortable? **Y / N**

JOAN G. LOVERING HEALTH CENTER
PO BOX 456 · Greenland, NH 03840 · (603) 436-7588

COUNSELING

The purpose of this worksheet is for discussion between you and a JGLHC counselor.
If you need privacy to complete this form, please see the person at the front desk.

1. When you first found out you were pregnant, what was your initial decision?

1	2	3	4	5	6	7	8	9	10
(Full term pregnancy)									(Abortion)

2. How **sure** are you of your decision *today*?

1	2	3	4	5	6	7	8	9	10
(Unsure)									(Confident)

3. Are you aware of all your options? _____

_____

4. What factors influenced your decision to come here today? _____

_____

5. Do you believe the decision to have an abortion is your own? If not, why? _____

_____

6. Does the man involved in this pregnancy know of your decision? Yes / No
If so, is he supportive of your decision? Yes / No

7. Who else, if anyone, is providing support around your decision? _____

8. Does anyone with you today require extra support from JGLHC-P? _____

9. Please circle all the words that describe how you feel: relieved sad angry confident happy numb ashamed resolved selfish sure peaceful anxious disappointed guilty comfortable

irritated grieving irresponsible hopeful Others: _____

10. How do you think you will feel after the abortion? _____

Please check what concerns you most TODAY:

- ____ a. Not sure of your decision to have an abortion
- ____ b. If this is confidential
- ____ c. Your relationship with your partner
- ____ d. Wondering how you will feel emotionally afterwards
- ____ e. If this going to hurt
- ____ f. Possible effects on future pregnancies
- ____ g. Possible complications during and/or after
- ____ h. When will I be able to resume normal activities?
- ____ i. Your relationship with your family
- ____ j. Your religious teachings or beliefs
- ____ k. Birth control options
- ____ l. Other: _____

11. Please include any other information you wish to share with us: _____

_____

Patient's Signature _____ Date: _____
Counselor's Signature _____ Date: _____