Wellspring Health Access
Patient Registration Form

CONTACT INFORMATION: We need accurate contact information to notify you of any abnormal medical findings. You ***must*** give us some way to contact you. If your phone does not accept blocked numbers, we may not be able to guarantee confidentiality. If this may cause a problem, please discuss this with a staff member. Non-identifying information may be used for program evaluation and research. ***In case of an emergency or life-threatening medical condition, confidentiality may be broken.***

PLEASE PRINT

Legal First Name_____M.I. _____

Legal Last Name _____

Preferred name (if different) _____

Date of Birth:_____Age:_____

Gender: _____

Address:_____Apt. # _____

City_____State_____Zip _____

Preferred Phone #_____

Alternate Phone #_____

Employer:_____

Occupation:_____

Who is here with you today?

_____

Emergency Contact

Name_____

Phone # _____

How did you hear about us?

☐ Internet ☐ Friend/Relative ☐ Yellow Pages

☐ Here Before ☐ NAF ☐ Other

☐ Doctor/Healthcare Provider _____

Insurance

Do you have Healthcare Coverage? _____

Please answer this question even if you plan to pay cash today. This helps us help you with contraception options and lab tests. Please give card to reception.

Insurance Name: _____

Are you also insured by Medicare/ Medicaid? _____

Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Insurance Policy #:_____

Group #: _____

Effective/Print Date: _____

Subscriber's Name: _____

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How would you like us to contact you?

Phone:_____or

Email:_____

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What services do you need today?

_____

I verify that I have answered these questions to the best of my ability. I am financially responsible for any balance due.

ULTRASOUND/FETAL HEART TONE CONSENT/CERTIFICATION

In accordance with the Wyoming Statutes, this form shall certify the following: I was offered the opportunity to view an active image of the ultrasound and to hear the fetal heart tones (if present) at the conclusion of the ultrasound preformed at Wellspring Health Access.

I have elected to:	Y	N
To view the sonogram	☐	☐
To listen to the fetal heartbeat (if present)	☐	☐
To receive a picture	☐	☐
To know if the pregnancy contains multiples	☐	☐

PATIENT NAME:_____**SIGNATURE**_____**DATE:**_____**TIME**_____

Reviewed and discussed by staff:_____DATE:_____

Physician Name:_____Signature:_____DATE:_____TIME_____

Wellspring Health Access
918 E 2nd Street
Casper, WY 82601
307.224.7852

Health Information Portability and Accountability Act
(HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the HIPAA privacy notice carefully.
Passage of HIPAA occurred to improve the efficiency and effectiveness of the health care system by standardizing the transmission of certain transactions and protecting the privacy and security of the patient's personal health information.
Privacy Rule essentially controls the use and disclosure of protected health information (PHI). The Security Rule protects and safeguards confidentiality of medical information and information that could identify an individual.
Wellspring Health Access understands that your medical information is private and confidential. All Physicians and staff must adhere to these policies.

As required by law, the HIPAA privacy notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. You can request a written copy of our most current privacy notice.
If you have any questions or would like furthering information about this notice, please contact Wellspring Health Access.

I,_____, acknowledge that I have been offered a copy of Wellspring Health Access' Privacy Notice and I have read that information that is posted in the lobby.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian (if minor) Date

Wellspring Health Access' Privacy Policy

I have read Wellspring Health Access' privacy policies and patient bill of rights and have been offered a copy.

_____ _____
Signature of Patient/Guardian Date

Wellspring Health Access' Advance Directive Policy

I have read Wellspring Health Access' Advance Directive Policy and have been offered a copy.

_____ _____
Signature of Patient/Guardian Date

Patient Consent for Text and Voice Appointment Reminders and Messaging

I authorize Wellspring Health Access to communicate with me via:

☐ Text and/or Voice at _____
☐ Email at _____

I DO ☐ OR ☐ Do NOT give my express consent to receive automated text and voice messaging to the number listed above.

Patient/Guardian Name _____
Patient/Guardian Signature _____

Wellspring Health Access
Health History

Please print your full name here:_____Date of birth:_____

Do you have any allergies to medications, metals, latex, rubber gloves, tape, shellfish, or antiseptic solutions (iodine/Hibiclens)?

No ☐ Yes ☐ *If yes, list allergy and reaction*_____

Have you ever had a bad reaction to anesthesia or sedation? ☐ NO ☐ YES *explain*:_____

Current medications:_____

SOCIAL HISTORY

No	Yes	
☐	☐	Do you smoke or chew tobacco? If yes, how many/much a day? _____
☐	☐	Do you drink alcohol? If yes, how often and how much?_____
☐	☐	Have you ever used street or IV drugs?_____

CONTRACEPTIVE HISTORY

Are you interested in getting birth control today? ☐ no ☐ **yes**,If what:_____

What birth control method are you currently using?_____

What methods have you used in the past?_____

Any problems with your previous methods? ☐ no ☐ yes If yes, explain:_____

PREGNANCY HISTORY (Please include current pregnancy)

When was the first day of your last menstrual period?_____Are you breastfeeding now? ☐ no ☐ yes

Number of: Pregnancies_____Vaginal deliveries_____ C-sections_____ Miscarriages_____Abortions_____Ectopic(tubal) _____

When did your last pregnancy end?_____Any complications? _____

PAST MEDICAL HISTORY Have you **EVER** had any of the following:

No	Yes		No	Yes	
☐	☐	Heart disease or serious heart valve problem	☐	☐	Uterine abnormalities/fibroids
☐	☐	Pulmonary Embolism (PE), heart attack, or stroke	☐	☐	Seizure or epilepsy
☐	☐	Bleeding problems or anemia	☐	☐	Asthma, breathing problems, other lung disease
☐	☐	Serious medical problems,hospitalizations,surgeries: _____	☐	☐	Migraine

REVIEW OF SYSTEMS: Do you ***NOW*** have any of the following:

No	Yes		No	Yes	
☐	☐	**Cardiovascular**: Severe chest pain	☐	☐	**Respiratory:** Difficulty breathing
☐	☐	**Neurological:** Migraine OR severe headache	☐	☐	**Genitourinary:** Severe/persistent pelvic pain
☐	☐	**Endocrine:** Excessive thirst or night sweats	☐	☐	**Genitourinary:** Abnormal discharge or itching
☐	☐	**Lymph:** Painful or swollen glands in your groin	☐	☐	**Genitourinary:** Severe pain with periods
☐	☐	**Gastrointestinal:** nausea or severe abdominal pain	☐	☐	**Mouth:** Bumps or sores in the mouth
☐	☐	**Chest/Breast:** lump, constant pain, or nipple discharge			

Patient signature:_____ Date:_____

Wellspring Health Access

Authorization for Release of Information to Family Members/Friends

Patient Name: _____ Date of Birth: _____
(PRINT)

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to friends/family members, you must sign this form. Only individuals listed on this form will be authorized to obtain/inquire about medical and billing information for the patient.

I authorize Wellspring Health Access to release and discuss my medical and/or billing information to the following

individual(s):

1. _____Relation to Patient:_____

2. _____Relation to Patient:_____

3. _____Relation to Patient:_____

_____I do not authorize any individuals to inquire/request medical information regarding my treatment at Wellspring Health Access.

PATIENT INFORMATION

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

I have the right to revoke this consent in writing at any time.

SIGNATURE:_____DATE:_____

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
AND CANCELLATION OF FUTURE APPOINTMENTS

Patient's Name:_____ Date of Birth: _____

Address:_____ Home Phone: _____

City, State, Zip: _____ Other Phone: _____

Email: _____

REQUESTING RECORDS FROM: _____
_____
_____
_____

MAIL OR FAX RECORDS TO: Wellspring Health Access
918 E 2nd St.
Casper, WY 82601
Phone: (307) 224-7852
Fax: (307) 224-7851

Please release medical records pertaining to the following:

_____

Reason for requesting records:

_____

****

I authorize the release of the above requested records, including those, which may contain confidential HIV/AIDS related information, confidential communicable disease related information, confidential information related to mental health, drug and/or alcohol use, or sexual history, and that the records be forwarded to the above name and address. I further authorize that these medical records may be faxed if necessary. I understand that I may revoke this authorization at any time, except to the extent that action based upon this authorization has already been taken. I have given my consent freely, voluntarily, and without coercion.

_____ _____ _____

Patient Signature (or parent/legal guardian if minor) | Relationship to Patient | Date

Wellspring Health
Access
Consultation
Worksheet

Name:_____

What options did you consider before makingyour decision? ☐ Abortion ☐ Adoption ☐ Parenting

Does the other person involved know about the pregnancy?

Are they supportive of your decision? ☐ Yes ☐ No ☐ Does not know.

On a scale of 1-10 (with 1 being very easy and 10 being very difficult), how hard was it for you to make this decision?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Who have you talked to about your pregnancy? ☐ Partner ☐ Parents ☐ Friends ☐ Other Family ☐ Spiritual/ Religious ☐ Other _____

Are you confident about your decision to terminatethis pregnancy? _____

Would you like more information about: ☐ Adoption ☐ Parenting ☐ Community Resources ☐ Pre-natal Care and/or Insurance ☐ Abortion Options ☐ other _____

If you drink alcohol or use drugs, please answer the following four questions:

Have you felt that you ought to cut down on your drinking or drug use? ___

Have people annoyed you by criticizing your drinking or drug use? ___

Have you felt bad or guilty about your drinking or drug use? ___

Have you ever had a drink or used drugs first thing in the morning to steady your nerves, to get rid of a hangover, or to get the day started? ___

<u>If you are under 18, you MUST answer the following two questions:</u>

Are you comfortable with the sexual experiences you have had? _____

Has your partner ever made you feel uncomfortable or pressured you in sexual matters? _____

Do you have any concerns today that you would like to discuss with the doctor or patient coordinator?

_____

_____

This portion of the form will be filled out during the consultation session.

The following has been discussed with the patient:

- ☐ Patient has considered all their options: abortion, adoption, and parenting.
- ☐ Patient has made own decision and expressed confidence in that decision.
- ☐ Patient's questions about the procedure and aftercare were discussed.
- ☐ Reviewed contraceptives and importance of completing the required follow-up.

Patient signature:_____Date:_____

Patient Coordinator signature:_____Time:_____AM/PM

Wellspring Health Access
Vital Statistics Reporting

The following information is required by Wyoming State law and is both confidential and anonymous.

Name_____
Age _____

Number of years of education (check one) ☐ 8th Grade or Less ☐ 9th-12th Grade (No Diploma) ☐ High School Graduate/GEDCompleted
☐ Some College Credit (No Degree) ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate or Professional Degree

Residence State_____County_____City_____Do you live in thecity limits? ☐ Yes ☐ No

Are you Hispanic? ☐ Yes ☐ No **If yes, please specify:** _____

Race:
☐ White ☐ Hispanic ☐ African American ☐ American Indian ☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Other:_____

Married:
☐ Yes ☐ No

Total number of pregnancies **NOT** including this one _____

Number of live births _____

Number of abortions _____

Number of priormiscarriages _____

Patients do not write below this line

Physician_____

Patient # _____

Date _____

Gestational age _____

Last Menstrual Period_____

Reason (check one) ☐ elective ☐ medical - mother / medical - fetus: ☐ anencephaly ☐ spina bifida ☐ other_____

Procedure (check one) ☐ Proced ☐ Medical ☐ D&E

Medical complication_____

Medical conditions _____

Medical emergency _____

Report number: _____

Wellspring Health Access
Mifeprex ® and Misoprostol Abortion Consent Form

I hereby give permission for Dr._____to perform a nonprocedural/medical abortion with Mifeprex® and Misoprostol.

Please initial each line below:

DESCRIPTION:

_____I am fewer than 11 weeks pregnant, and I have decided to have an abortion with the medications Mifeprex ® and Misoprostol. These medications will cause an abortion by starting cramping and vaginal bleeding like a heavy period or miscarriage. This method allows a pregnant woman to have an abortion without putting instruments into the uterus.

_____Mifeprex ® is a drug which blocks the action of progesterone, a hormone needed to continue the pregnancy. Mifeprex ® has been approved by the U.S. Food and Drug Administration (FDA) for early abortion and has been used by millions of women in Asia and Europe (it has been referred to as "RU-486" or the "French abortion pill"). Misoprostol is a drug used in the United States to prevent irritation or ulcers in the stomach. When the FDA approved Mifeprex®, it was approved for combination with Misoprostol. Studies have shown that Mifeprex ®and Misoprostol, when used together, are approximately 95% effective in causing an abortion in early pregnancy.

PROCEDURE:

_____An ultrasound will be done to determine how far along my pregnancy is. The ultrasound will be done by putting the ultrasound probe in my vagina. The only purpose for this ultrasound is for gestational dating, to ensure an intrauterine pregnancy and to identify the placental location if needed. It is not for other diagnostic purposes.

_____I consent to the taking and testing of blood samples. I understand these tests are routinely performed and are a necessary component of my care to check my blood type and for anemia.

_____I will swallow 200 mg Mifeprex ® (one tablet). 24-36 hours later, I will place 800 mcg Misoprostol in my mouth as instructed. If my gestation is between 9.0-11.0 weeks, I will place another 800 mcg Misoprostol in my mouth as instructed, 4 hours after the first dose.

_____ I will remain at home and plan to relax for the next 6 hours when bleeding and cramping will likely occur. I understand that I will have access to a telephone and Wellspring Health Access' 24-hour emergency contact information.

_____I will contact my provider at 307-224-7852 if: I soak 2 or more maxi pads per hour for 2 consecutive hours; I have onset of fever (100.4) more than 1 day after Misoprostol; I have severe abdominal pain not helped by pain medicine; or I have no bleeding within 24 hours after Misoprostol, which may require more medication or evaluation for an ectopic pregnancy.

_____I will complete a follow up appointment as instructed by clinic staff 28-30 days from the date of procedure. This follow-up appointment is ***very*** important to confirm that termination of my pregnancy has occurred and that there have been no complications. If my pregnancy has ended, then I am done.

RISKS may include:

_____Incomplete Abortion: As with a procedural abortion, some pregnancy tissue may remain in my uterus. If this occurs, the provider will discuss my treatment options, which may include waiting one or more weeks, using more Misoprostol, or having an aspiration, which is similar to a procedural abortion. If I decide to wait or use more Misoprostol, and the abortion is still not complete, I will need an aspiration curettage. The risks of an aspiration curettage include a risk of making a hole in the uterus, tearing the cervix, adverse reaction to anesthesia that may be used, infection, excessive bleeding, and failure to remove all the tissue from the uterus.

_____Vaginal bleeding: As with the procedural abortion, heavy bleeding can occur, and blood clots may come out of the vagina. If I have extremely heavy bleeding or dizziness, an aspiration curettage may be necessary to stop the bleeding. The risks of the aspiration curettage are stated above. The risk of having very heavy vaginal bleeding after Mifeprex ® /Misoprostol is about 1 per 100 (1%). The risk of needing a blood transfusion after using Mifeprex ® / Misoprostol is about 1 per 1000 (0.1%).

_____Continued pregnancy and birth defects: My pregnancy may not end after receiving the medications. If this happens, birth defects are possible. Because of the risk of birth defects, I know that a procedural abortion is strongly recommended to end the pregnancy. The risks of a first-trimester procedural abortion are as above.

_____Side effects: The following side effects are possible (10-15%): nausea, vomiting, diarrhea, fever, headaches, and chills. Most of these side effects last less than a day. I will have cramping in my lower abdomen and may need pain medications for this reason.

_____Ectopic pregnancy: A rare condition (2%), which is a complication of pregnancy rather than the abortion, is an ectopic pregnancy or a pregnancy in the fallopian tube. I understand that if the pregnancy is in the fallopian tube or outside the uterus, neither a procedural abortion nor a Mifeprex ® /Misoprostol abortion will remove the pregnancy, and due to the possible threat of rupture of the fallopian tube, hospitalization may be necessary as soon as it is discovered.

_____Infection: There is a very rare risk of serious bacterial infection after a medical abortion. There is a 1 in 100,000 risk of developing fatal septic shock. There would be a risk of developing this infection following childbirth, miscarriage, procedural abortion or after other types of surgeries. If more than 24 hours after taking the second medicine (Misoprostol) I have severe abdominal pain or discomfort, or am 'feeling sick' including weakness, nausea, vomiting or diarrhea, with or without fever, I will contact the physician right away. If I visit an emergency room or another health care provider who does not prescribe Mifeprex ®, I will tell them I am undergoing a medical abortion. I understand this risk is higher than procedural abortion and accept this risk.

_____It is unknown if antibiotic use might prevent this very rare infection. Our physicians feel it could help and recommend an antibiotic. Many providers are doing this, and they will be provided for you to take as directed.

_____Death: 1 per 160,000. In comparison, a woman's risk of death during pregnancy and childbirth is ten times greater.

COSTS AND PAYMENTS:

_____I will receive medical care for my abortion as described above (including information about birth control). This fee includes payment for a procedural abortion if needed. The fee does not include charges incurred for an emergency room visit or for care at another facility.

VOLUNTARY CONSENT:

_____I have been informed of other choices during early pregnancy including continuing the pregnancy and becoming a parent, continuing the pregnancy, and making adoption arrangements, and procedural abortion. I have been informed of the risks involved with a procedural abortion and a medical abortion, and the risks involved with continuing the pregnancy. I understand that I may choose to have a procedural abortion at any time after I start the medical abortion, although I will need to pay for this care if it is not medically necessary.

_____I have fully disclosed my medical history including the date of my last menstrual period, allergies, blood conditions, prior medications or drugs, and reactions to medications or drugs. I certify that I have read this form or that it has been read to me. I understand its contents, and any questions have been answered to my satisfaction. I certify that I have been given the Mifeprex ® Medication Guide and that I have had an opportunity to read it and discuss it with my provider.

Medical Provider's Signature	**Patient Signature**	**Date**

_____**Parent or Guardian Signature (if patient is a minor)**

Medication Follow-Up Agreement

Today you will take a medication called Mifeprex (mifepristone).

You will take a second medication called Misoprostol 24-36 hours from the time you take the Mifeprex. If your gestation is between 9.0-11.0, you will take a second dose of Misoprostol 4 hours after your first dose.

There is a 1-5% chance that you may still be pregnant after taking these medications. If you are still pregnant, you will need to have a procedural abortion OR take another dose of Misoprostol.

You **must** follow up with our office for a follow-up phone call 28-30 days after your first appointment. You will be given detailed instructions on how to complete a pregnancy test and follow up phone call with our office.

If during your follow up phone call, it is determined that you may still be pregnant, you **MUST** return to our office for a procedural abortion or another dose of Misoprostol.

You have 30 days from the procedure date to complete a follow-up appointment.

If you do not complete a follow-up appointment within 30 days, and it is determined that you need continuing medical care, you will be charged full price for additional services. These services may include a procedural abortion and the cost of the abortion is based on gestation.

Patient Name (PRINTED): _____

Patient Name (SIGNATURE): _____

Date: _____

Authorization to Bill Insurance

I decline to have my insurance billed for the services received today. If you agree to have your insurance billed, skip to Section 1, and complete the rest of the form.

Patients Printed Name:_____Date of appointment: _____
Patients Signature: _____

If you agree to have your insurance billed for the services received, please continue to fill out the information below.

SECTION 1: Patient Information

Last Name:_____First Name_____Middle Initial: _____

DOB:_____SS#:_____ Daytime Phone: (_____)_____

SECTION 2: Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name:_____First Name:_____Middle Initial: _____

Address:_____City:_____State:_____Zip:_____
Phone: _____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

_____ _____
Guarantor's Signature **Date**

I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency, and I will be responsible for any fees generated as a result of collection efforts. I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Wellspring Health Access to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

X _____ _____
Patient's Signature Date

X_____ _____
Guardian/Representative's Signature Date

_____
Relationship to Patient/Representative Authority