REQUEST FOR SERVICES

Name____ DOB__________________

Address______________________________________ City ____________Zip__________

Email Address ____

Phone number_________________________ May we contact you? __________________

Have you been here before? ______ If yes, under what name? _______________________

How did you hear about us? ____

The following services are offered to clients of the pregnancy center. Please indicate any service in which you have a particular interest.

Direct Services

☐ Pregnancy test
☐ Ultrasound
*Ultrasound is purely educational In that it affirms life in the womb
☐ Material Assistance
*Material assistance may include diapers, baby clothes, and basic toiletries

Information/Counseling

☐ Pregnancy
☐ Abortion procedure/risks
☐ Adoption/Foster care
☐ Parenting
☐ Prenatal care
☐ Post abortion
☐ Other

Referrals

☐ Medical Care
☐ Social Services
☐ Prof. counseling
☐ Housing
☐ Adoption/foster
☐ Other

LIMITATION OF SERVICES

The Pregnancy center is staffed by volunteers who have received training as an advocate. The volunteers and paid staff, for the most part, do not have degrees in counseling nor are they licensed by the state, therefore, the counseling provided is not intended to be a substitute for professional counseling.

THE PREGNANCY CENTER DOES NOT PERFORM NOR REFER FOR ABORTION

To protect your privacy and the privacy of our peer advocates, any use of electronic recording devices during your peer session is not permitted.

The center services and resources are intended for all persons who genuinely seek our caring help. Any attempt to obtain services or resources from the center under false pretenses is also not permitted.

I understand that the pregnancy center will hold in strict confidence all the information I provide them except as required by law or when necessary to protect others or myself against a threat of harm.

I understand the above and willingly enter into a relationship of accepting help and assistance from the pregnancy center.

Your signature____Date________________

4/7/20

NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

BECAUSE WE ARE NOT A MEDICAL CARE PROVIDER, AND ALSO DOES NOT ENGAGE IN ANY TRANSACTIONS THAT INVOKE COVERAGE OF THE HIPAA PRIVACY ACT, THE PRIVACY PRACTICES AND TERMS DESCRIBED IN THIS NOTICE ARE VOLUNTARILY UNDERTAKEN. THEREFORE, NOTHING IN THIS NOTICE SHOULD BE CONSTRUED AS CREATING ANY CONTRACTUAL OR LEGAL RIGHTS ON BEHALF OF CLIENTS. WE RESERVE THE RIGHT TO MODIFY OUR PRIVACY PRACTICES AND THIS NOTICE AT ANY TIME.

II. **Safeguarding your protected health information**

Individually identifiable information about your past, present, or future health or condition, and the provision of care to you is considered "Protected Health Information" (PHI). We will extend certain protections to your PHI. This notice explains how, when and why we may use or disclose your PHI. Except in specified circumstances, we will only use or disclose the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

III. **How we may use and disclose your protected health information**

We use and disclose PHI for a variety of reasons. We may use and/or disclose your PHI for purposes of treatment or our center's care operations. For uses beyond that, we will ordinarily obtain your written authorization. The following offers more description and some examples of the potential uses and disclosures of your PHI:

Uses and disclosures relating to treatment or our center's care operations. We may disclose your PHI to doctors, nurses, and other health care personnel who are involved in providing your health care. Your PHI may be shared with outside entities performing ancillary services to your treatment. Also, we may use and/or disclose your PHI as may be reasonably necessary in the course of operating our center. We may also send or communicate appointment reminders but subject to our normal confidentiality policies and any special instructions that you have given.

Uses and disclosures for which special authorization will be sought. For uses beyond treatment and operation purposes, we will ordinarily seek to obtain your authorization before disclosing your PHI. However, disclosure of your PHI may be made without your consent or authorization when required by law, when required for public health reasons, when necessary to avert a threat of harm to you or a third person or party, or when other circumstances may require or reasonably warrant such disclosure.

IV. **How you may have access to or control of your protected health information (PHI).**
The following is a description of the steps you may take to access or to otherwise control the disposition of your PHI:

To request restrictions on uses/disclosures: You may ask that we limit how we use or disclose your PHI. We will consider your request, but we are not legally bound to agree to the restriction. To the extent that we do agree to such restrictions, we will abide by such restrictions except in emergency situations. We cannot agree to limit uses/disclosures that are required by law.

To choose how we contact you: You may ask that we send you information at an alternative address or by alternative means. We will agree to your request so long as it is reasonably easy for us to do so.

To inspect and copy your PHI: Unless your access is restricted for clear and documented treatment reasons, you will be permitted to inspect your protected health information upon written request. We will respond to your request within 30 days. If we deny your request for access, we will give you written reasons for the denial. If you want copies of your PHI, we will make reasonable efforts to accommodate any such request. You may designate selected portions of your PHI for copying.

To request amendment of your PHI: If you believe that there is a mistake or missing information in our record of your PHI, you may request in writing that we correct or add to the record. We will respond within 60 days of receiving your request. Any denial will state the reasons for the denial. If we approve the request for amendment, we will change the PHI and so inform you. We will also inform any others who have a need to know about such changes.

To find out what disclosures have been made: You may request for us to provide you with a list of all disclosures of your PHI which we have made except for such disclosures as have been made in connection with your treatment, our center's operations, or as specifically required by law. We will respond to your request within 60 days of receiving it.

To receive this notice: You may receive a paper or electronic copy of this notice upon request.

V. **Contact person:** If you have any questions or concerns about our privacy practices, please contact:

VI. **Acknowledgment:** I have reviewed this privacy policy notice: ____________ (Date)

Printed Name__________________________________

Signature _____________________________________

Acknowledgement of Receipt of Privacy Notice

I have read the privacy notice for Creative Choices Pregnancy Resource Center.

Please initial your preference regarding a copy of the privacy notice.

I received a copy of the privacy notice:___________________________________

I declined a copy of the privacy notice: __________________________________

Client signature:_________________________________ Date:_______________

Witness:_______________________________________ Date:_______________

Medical History & Assessment Creative Choices PRC

(completed by medical staff)

Patient Name: ____ Date of Birth: ______________

Plans for pregnancy before sonogram:

Plans for pregnancy following sonogram:

□ Are you in prenatal care? O Yes O No

□ Pregnancy confirmed by positive test: Date __ /___/___ Test performed by: ______________________

□ LMP________________ Gestational age by LMP_____________ ***(No U/S if less than 6 weeks LMP)***

□ Any medical concerns related to this pregnancy, i.e. history of BP elevation, drug/alcohol use since LMP:

□ Pre-existing medical conditions: ("Do you have a history of any medical conditions that you believe or have been told would make it unwise to carry your pregnancy to term?"). If yes, explain:

□ History of Tubal Ligation or Ectopic Pregnancy? O Yes O No (***If yes, sonogram will not be performed.)***

□ IUD in place? O Yes O No ***(If yes, sonogram will not be performed.)***

□ History of STIs? O Yes O No PID? O Yes O No Treatment Date: _____/_____/_______

Follow-up since treatment:

□ **Allergic to latex** (Condoms) O Yes O No

□ **Complaints of pain** (check all that apply)

O None

O Onset - Duration: ______________________________________ Date: _____/______/________

O Severity (scale 0-10 with 10 being worst):

(Severe pain: >6-send to ER - do not do sonogram)

O Constant / Intermittent/ Increasing (*Circle all that apply*)

O Describe any pain and its location:

O Urinary Symptoms: O Yes O No If yes, describe:

O Pain greater than menstrual cramps? O Yes O No ***(If yes, sonogram will not be performed.)***

O Any pain medication prior to arrival? O Yes O No

If yes: What? How Much? When?

□ **Are you having vaginal bleeding?** O Yes O No ***(If active bleeding, sonogram will not be performed.)***

□ Instructions given:

O Miscarriage: O Yes O No | O Blood Type: ________________________

O Ectopic/Tubal Pregnancy: O Yes O No | O Concerns regarding Rh factor:

Comments:

Signature: ____ Date:___ /____/____

(medical staff)

5/6/19

Verification of Positive Pregnancy Test

Date ___________________________

RE: Verification of Positive Pregnancy Test

To whom it may concern:

This is to verify that ____

Self-administered a pregnancy test at Creative Choices Pregnancy Resource Center on

________________________ (today's date).

The test results were read positive. Her EDC based on her LMP is ________________.

Signed,

____

Certified Pregnancy Test Personnel

CREATIVE CHOICES PREGNANCY RESOURCE CENTER

STATEMENT OF SELF-ADMINISTERED PREGNANCY TEST

I, ________________________________, understand there is no physician staff on-site at Creative Choices Pregnancy Resource Center (CCPRC). The result of my self-administered test cannot be verified and a diagnosis of pregnancy cannot be given. Only a licensed physician can make a diagnosis.

I took a self-administered pregnancy test at Creative Choices Pregnancy Resource Center according to the manufacturer's instructions.

I did not receive assistance in the actual administration of the pregnancy test. Nor did I receive from CCPRC an interpretation of the results, as stated above I understand that only a physician can make that diagnosis.

According to the manufacturer's instructions, the pregnancy test result appeared to be:

Circle one Reading

POSITIVE NEGATIVE INCONCLUSIVE

I have read and fully understand the above as stated.

Signature: ____ Date: ___/____/_____

Medical Services Consent & Release Creative Choices PRC

Name ____ Date of Birth ____________

Address____ Phone ___________________

City __________________________State_______ Zip _______Cell Phone _________________

I request an appointment for a limited ultrasound examination at Creative Choices Pregnancy Resource Center for the purposes of confirming my pregnancy. I understand that the appointment will be limited to pregnancy confirmation and that a referral will be made to another medical provider for follow-up medical care.

I understand that a limited ultrasound examination is only for the purposes of confirming my pregnancy, detecting fetal cardiac activity, determining estimated gestational age and for familial reasons relating to maternal health. I understand that it is not for the purposes of diagnosing or detecting any medical problem or condition for my baby or for myself. I will not hold Creative Choices Pregnancy Resource Center responsible for diagnosing or failing to diagnose any abnormalities or conditions relating to my pregnancy or my baby and hereby release Creative Choices Pregnancy Resource Center from any and all liability in this regard.

I understand that ultrasound utilizes high frequency sound waves, and that there are no known harmful effects in its more than thirty years of clinical use. I further understand that the possibility always exists that effects may be identified in the future.

I understand that no follow-up care will be provided at Creative Choices Pregnancy Resource Center and its physicians and staff are not responsible for my follow-up prenatal care, and are not responsible for emergency care that I may need. I understand that a referral list with the names of local doctors and prenatal health care providers is available for my use. I acknowledge that I have the duty and responsibility to use the referral list or some other source to secure my prenatal care.

I am not presently experiencing any immediate medical problem (e.g., pain, spotting, cramping), and I understand that this exam is not a substitute for immediate medical care. Should any medical problems arise before my scheduled appointment(s) at Creative Choices Pregnancy Resource Center, I acknowledge that it is my responsibility to seek emergency care.

I hereby give full consent to these medical services and I waive and release any and all claims of whatsoever kind and nature that I, my baby, my legal representatives or heirs and relatives might have, or hereafter have, against Creative Choices Pregnancy Resource Center, its physicians, medical personnel, directors, officers, employees and volunteers.

I expressly agree that this waiver, release and indemnity agreement is intended to be as broad and inclusive as permitted by the laws of this state, and that if any portion thereof is held invalid, it is agreed that the balance shall, not withstanding, continue in full legal force and effect.

In order to effectively provide for my medical care, I understand that the volunteer staff and client advocates of Creative Choices Pregnancy Resource Center will have access to my confidential records at Creative Choices Pregnancy Resource Center. My records will not be released to any agency or individual without my permission except as required by law.

I give CCPRC permission to contact me by phone or letter for follow-up.

I have read and understand and agree with this statement.

Date: ______________ ____________________________________ ________________________

Patient Signature Print Name

Date: ____/____/______ ____ Sonographer

LIMITED ULTRASOUND REPORT   Creative Choices PRC

Name____   Date of Birth _____/_____/______

LMP ______________ EGA by LMP ______________ EDC by LMP _____________

Indication for Ultrasound: ______ Confirm viable intrauterine pregnancy   ______Dating

_______ Familial factors related to maternal health

ULTRASOUND:

◯ Abdominal U/S   ◯ Transvaginal U/S

IUP: ◯ Yes ◯ No   Yolk Sac Seen: ◯ Yes ◯ No

Fetal Heart Motion: ◯ Yes ____________ BPM ◯ No

Multiple Pregnancy: ◯ Yes ◯ No

ULTRASOUND MEASUREMENTS:

GS: _________mm. ______wks _______ days (Note: DO NOT measure GS when CRL is visible)

CRL: _______ mm. ______ wks _________days

BPD: _______ mm. ______ wks _______ days

EDC (by U/S): _______________________

Comments:

Present for Ultrasound:____

Sonographer: ____ Date: _____/_____/______

Medical Director: ____ Date:_____/_____/______

Comments:

7/2017

Creative Choices
PREGNANCY RESOURCE CENTER

CLIENT COMMENTS

Your name (optional)___________________________________Today's date______________

Would you take a moment to help us improve our services? We want to be as helpful as we can to women in this community, and having just been served here, you know better than anyone else how we are doing. Please respond honestly. Thank you for your feedback!

Who did you see today? ______________________________

Did the individual seem interested in you and your needs? *He/she was..*

___Very interested
___Somewhat interested
___Uninterested ___Unsure

Was this individual sensitive and respectful of your beliefs? *He/she was…*

___Very sensitive
___Somewhat sensitive
___Insensitive ___Unsure

Did you feel that this individual understood your feelings and needs?
I felt that he/she understood me…

___Very well
___Somewhat well
___Not very well ___Unsure

Did you feel comfortable talking to this individual about personal issues?
I felt…

___Very comfortable
___Somewhat comfortable
___Uncomfortable ___Unsure

Was the information that this individual provided helpful to you?
The information was…

___Very helpful
___Somewhat helpful
___Unhelpful ___Unsure

2/25/19

Were the center services (free pregnancy test, counseling, clothing, medical and legal referrals, etc…) helpful to you?
The services were…

___Very helpful
___Somewhat helpful
___Unhelpful ___Unsure

Would you recommend the center to a friend who was facing a crisis pregnancy?
I would…

___Strongly recommend it
___Somewhat recommend it
___Discourage it ___Unsure

What did you like best about the pregnancy center?

How could we be more helpful to someone in your situation?

Would you allow us, after getting written permission, to share information with others about your experience here?

___Yes ___No

(If you answer "Yes", please include your name and other necessary information so that we may get in touch with you.)

Thank you for helping us do our best! Please use the back of this form if you need more space for comments.

Authorization for Release of Health Information Pursuant to HIPAA

I request that health information regarding my care and treatment be released as set forth on this form and in accordance with the Privacy Rule of the health Insurance Portability and Accountability Act of 1996 (HIPPA).

I understand that:

1. I hereby authorize release of my information by ______________________ in any secure manner; including via facsimile, secure e-mail and telephonically.

2. I have the right to revoke this authorization at any time by writing to the healthcare providers listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

3. I understand that signing this authorization is voluntary.

4. THIS AUTHORIZATION DOES NOT ATHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE AGNCIES LISTED HEREIN.

5. Name and address of agencies to whom you are authorized to release information:
   Dare County Health Department
   Dr. Dwyer

6. Specific information to be released:
   Medical Records from ___/___/___ to ___/___/___
   Verification of Positive Pregnancy Test
   Material Assistance Provided
   Other: _____________________________________

7. Date or event on which this authorization will expire: one year after delivery

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

Patient's name: ____ Date of Birth _________
(print clearly)

____ Date: _________ SSN _____-____-________
(Patient Signature)

____ Date: ___/___/___
(Staff Signature)

CREATIVE CHOICES PREGNANCY RESOURCE CENTER

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Circle one Reading

POSITIVE NEGATIVE INCONCLUSIVE

I have read and fully understand the above as stated.

Signature: ____ Date: ___/____/_____

In-Center Coronavirus Screening Form Today's date: _________________

Dear Creative Choices Pregnancy Center Visitor,

Because of the coronavirus pandemic, we are asking everyone who comes to the center to complete this form.

- We kindly request that you complete your form in your vehicle for the health and safety of others.
- Once you've completed the form, call this number 252-441-1818 to speak with the receptionist about an appointment.

Please answer the following questions truthfully:

1. Are you currently experiencing:
   a. Fever: Yes/No; Explain: ____
   b. Cough: Yes/No; Explain: ____
   c. Shortness of breath: Yes/No; Explain: __________________________________
2. Have you been in close contact with any person who has/had the corona virus? Yes/No
3. Have you recently travelled from a region where Corona virus is active? Yes/No

Your name: ____

Your address: ____

Your phone number: ____

Please call 252-441-1818 once you have completed this form.

Please give this form to a Creative Choices Pregnancy Center staff person.

When inside the Center please remain 6' from other when at all possible.

No visitors will be allowed in with the client.

Thank you for doing your part to keep our community healthy!

The Creative Choices Pregnancy Center Team

STAFF ONLY

Client/Patient ID ________ Screened by: ___________________________________ (personnel name)

Recommendation made: ____