# Affiliated Medical Services (AMS)

## Privacy Policy

I have been provided *The Notice of Privacy Practices of Affiliated Medical Services, Inc.* and I understand that as part of my healthcare, AMS originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services were provided
- a tool for routine healthcare operations such as assessing quality and reviewing the skill of the healthcare professionals.

I understand that I have the right to review the notice prior to signing and to request a copy of the notice for my personal use. I also understand that AMS reserves the right to change their notice and practices and that I can request, in writing, any revised notice. I understand that I have the right to request restrictions as to how my information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action.

I have been given ample time to ask questions regarding *The Notice of Privacy Practices of Affiliated Medical Services, Inc.* and I understand that AMS will hold my record to the highest standard of privacy and confidentiality. AMS will only release my personal health information when authorized by me in writing or when required by law to do so.

A copy of our policy is available upon request.

_____ _____

Signature Date

**Affiliated Medical Services**
1428 N. Farwell • Milwaukee, WI 53202

Number_____
Date ___/___/___

## Abortion Health History

**ASSURANCE OF CONFIDENTIALITY:** This medical record is confidential and will not be released to anyone without your written consent except as may be required by law. It is your responsibility to give complete and accurate information.

PLEASE PRINT

Cell Phone ( )_____

Name _____ Home Phone ( )_____
Last First Maiden

Address _____
Street City State Zip

_____
County Social Security No. Date of Birth Age

Marital Status: ❑ Never Married ❑ Married ❑ Widowed ❑ Separated ❑ Divorced
Race: ❑ White ❑ Black ❑ Native American ❑ Asian ❑ Hispanic ❑ Other, list _____
How many years of school completed? _____ How many years of college? _____
Have you ever been at this clinic before? ❑ Yes ❑ No If yes, when ____/____
mo yr

EMERGENCY CONTACT: Name_____ Phone: ( ) _____

Partners relationship: ❑ Husband ❑ Boyfriend ❑ Friend ❑ Other _____
Dominant Decision Maker: ❑ Yourself ❑ Parents ❑ Husband ❑ Boyfriend ❑ Other _____

If you are 9 weeks pregnant or less, you may be eligible for a medical abortion (using pills).
Check here for more information: ❑
If you are planning a surgical abortion, do you want: ❑ Local anesthetic ❑ Moderate sedation
Please list any medications that you are currently taking, including asthma pumps (inhalers):

_____

Do you smoke cigarettes? ❑ Yes ❑ No
Do you use street drugs? ❑ Yes ❑ No If yes, what type _____ When last used? _____
Do you use herbs? ❑ Yes ❑ No If yes, what_____

Are you allergic to any medications? ❑ Yes ❑ No
If yes, what medication? _____
What happens when you take this medication? _____
Are you allergic to any of the following:
❑ Shellfish ❑ Iodine ❑ Latex ❑ Metals ❑ Other

Do you, your mother, father, sister, or brother have diabetes? ❑ Yes ❑ No
Are you adopted? ❑ Yes ❑ No
Did you ever have diabetes during pregnancy: ❑ Yes ❑ No

**PREGNANCY HISTORY**

First day of last normal period ____/____/____
mo day yr

How many times have you been pregnant?

_____

When did your last pregnancy end?____ mo.____ yr

Types of deliveries: ❑ Vaginal ❑ Caesarean ❑ None

Complications with any pregnancies? ❑ Yes ❑ No

Are you currently breast feeding? ❑ Yes ❑ No

**CONTRACEPTIVE HISTORY**

Were you using a method of birth control when you got pregnant this time? ❑ Yes ❑ No

If yes, what method?_____

_____

What method of birth control do you want now?

_____

_____

AMS 117 7/10

Name: _____ Date ___/___/___

| Do you now have, or have you ever had: | Yes | No | STAFF COMMENTS |
|---|---|---|---|
| Serious illness/hospitalizations/surgery | | | |
| Cancer | | | |
| Seizures/Mental Health Issues/Diagnosis | | | |
| Asthma | | | |
| Heart problems/murmurs/Rheumatic fever | | | |
| High blood pressure, stroke | | | |
| Blood clots in veins | | | |
| Bleeding tendencies | | | |
| Breast lump/surgery/nipple discharge | | | |
| Liver infection/problems | | | |
| Pain/burning or frequent urination | | | |
| Unusual vaginal discharge/odor/bumps/sores | | | |
| Vaginal infections/Group B strep | | | |
| Gonorrhea, chlamydia | | | |
| Infection of uterus, tubes, ovaries | | | |
| Uterine growths/fibroids/abnormality | | | |
| Cryotherapy/laser/LEEP on your cervix/abnormal pap smear | | | |
| Annual exam or pap in the past year | | | |
| HPV vaccination | | | |

The above information is accurate and complete.

Signature of Client _____ Date _____

**Area below for staff use**

Staff Comments:

Weeks pregnant: _____

Decision to end pregnancy ❑ Firm ❑ Uncertain

State mandated protocol followed ❑ Yes ❑ No

Procedure explained ❑ Yes ❑ No

Sedation options discussed ❑ Yes ❑ No

Advised of moderate sedation benefits, risks, side effects ❑ Yes ❑ No

Safety concerns addressed ❑ Yes ❑ No

Recovery restrictions discussed ❑ Yes ❑ No

Questions answered ❑ Yes ❑ No

Birth control pamphlet given ❑ Yes ❑ No

Work excuse needed ❑ Yes ❑ No

Staff Signature _____ Date _____

AMS 117 7/10

# ABORTION INFORMATION PROVISION CERTIFICATION FORM

**Completion of this form by the patient is required under Wisconsin State Statute 253.10**

An exemption to the 24-hour wait period may be allowed if the pregnancy is the result of a sexual assault or incest or if there is a medical emergency.

_____ (name of physician) orally informed me, in person, on

_____ (date) at _____ a.m./p.m. of the following:

That, according to my physician's reasonable medical judgment, I am pregnant and the probable gestational age of the fetus, on this date, is _____ weeks.

☐ 1. The probable anatomical and physiological characteristics of the fetus on this date.

☐ 2. That fetal ultrasound imaging and auscultation of fetal heart tone services are available that enable viewing the image or hearing the heartbeat of the fetus and how these services can be obtained.

☐ 3. The particular medical risks, if any, associated with my pregnancy.

☐ 4. The details of the medical or surgical method that would be used in performing or inducing an abortion.

☐ 5. The medical risks associated with the particular abortion procedure that would be used, including the risk of infection, psychological trauma, hemorrhage, endometritis, perforated uterus, incomplete abortion, failed abortion, or danger to subsequent pregnancies and infertility.

☐ 6. The recommended general medical instructions to follow after an abortion to enhance safe recovery, and the name and telephone number of a physician to call if complications arise.

Physician's telephone number: 414 278 0424

☐ 7. If, in the reasonable medical judgment of my physician, the fetus has reached viability, that the physician who is to perform or induce the abortion is required to take all steps necessary under law to preserve the life and health of the fetus.

☐ 8. That I have the right to withdraw consent, cancel the appointment or not show for the appointment at any time before the procedure is performed.

☐ 9. That no payment for the procedure may be required from me until at least 24 hours have elapsed after the informed consent consultation has been completed, except if the waiting period is shortened by me because the pregnancy is the result of sexual assault or incest.

I certify that this information was provided in an individual setting that protected my privacy, maintained the confidentiality of my decision and ensured that the information focused on my individual circumstances but that did not prevent me from having a person of my choice present. I certify that I was allowed adequate opportunity to ask questions and all my questions were answered in a satisfactory manner.

_____ _____

Patient Date

_____ _____

Parent, guardian, legal custodian, adult family member, foster parent or treatment foster parent, if applicable for a minor Date

_____ _____

Guardian of patient who has been adjudicated incompetent if applicable Date

_____ (name of physician or name and professional title of qualified person assisting the physician) orally informed me, in person, on _____(date) at _____ a.m./p.m. of the following:

(The information noted in items 1-3 on this page may be omitted if the fetus has a diagnosis of a lethal anomaly.)

☐ 1. That benefits may be available to me under the Medical Assistance Program to pay for prenatal care, childbirth and neonatal care.

☐ 2. That the man responsible for my pregnancy is liable for providing assistance in supporting my child, if born, even if he has offered to pay for the abortion.

☐ 3. That I have the legal right to terminate my pregnancy or to continue my pregnancy and to keep my child, place my child in a foster home or treatment foster home for six months or petition a court for placement of the child in a foster home, treatment foster home or group home or with a relative or place the child for adoption under a process that involves court approval both of the voluntary termination of parental rights and of the adoption.

☐ 4. That I have the right to receive and review, free of charge, state-printed materials that contain information on the development of the fetus.

☐ 5. That, if I have received a diagnosis of a disability for the fetus, I have the right to receive and review free of charge, information on community-based services and financial assistance programs for children with disabilities and their families, support groups for people with disabilities and parents of children with disabilities, and adoption of children with special needs.

☐ 6. That I have the right to receive and review, free of charge, information on the availability of public and private agencies and services that provide birth control information including natural family planning information, agencies that offer alternatives to abortion, and information about legal protections for me and my child should I wish to oppose establishment of paternity or to terminate the father's parental rights.

The information listed in items 5 and 6 is available through a toll-free telephone number (1-877-855-7296) as well as state-printed materials.

I certify that this information was provided in an individual setting that protected my privacy, maintained the confidentiality of my decision and ensured that the information focused on my individual circumstances but that it did not prevent me from having a person of my choice present. I certify that I was allowed adequate opportunity to ask questions and all my questions were answered in a satisfactory manner. I certify that the printed materials were physically given to me.

_____ _____

Patient Date

_____ _____

Parent, guardian, legal custodian, adult family member, foster parent or treatment foster parent, if applicable for a minor Date

_____ _____

Guardian of patient who has been adjudicated incompetent, if applicable Date

(To be filled in by the physician who is to perform or induce the abortion or qualified person assisting the physician.)

The name of the physician who is to perform or induce the abortion is _____.
Each item of information referred to in the nine numbered paragraphs on page one and the six numbered paragraphs on this page must be supplied unless the physician determines a particular item of information would cause a significant, non-temporary threat of severe harm to the woman's mental health. This form is to be placed in the patient's medical records and a copy provided to the patient.