LIFE CHOICES MEDICAL CLINIC dba THE SOURCE DATE:_____

Patient Intake Form

Please print clearly.

Contact Information

First Name _____ Last Name _____

Address _____ City, State _____ Zip _____ County _____

Phone Number: _____ (SSN)_____

Emergency Contact (Name/Relationship) _____ Phone _____

Email _____ U.S. Citizen? YES / NO

☐ Contact by Mail OK ☐ Contact by E-Mail OK ☐ Leave message OK ☐ Text OK
☐ Can we identify as "Life Choices Medical Clinic"

Do you currently have Insurance? ☐ No ☐ Healthy Texas Women ☐ Medicaid ☐ Chip ☐ Other_____

Birth Date (mm/dd/yyyy) _____ Age _____ Drug Allergies? _____

Demographic Information

Please check only ONE for each of the following, unless otherwise noted:

Race:

☐ African American ☐ Caucasian ☐ Hispanic/Latin American ☐ Other
☐ Asian/Pacific ☐ East Indian ☐ Native American ☐ Unknown

Marital Status:

☐ Divorced ☐ Married ☐ Single ☐ Widowed
☐ Engaged ☐ Separated ☐ Common law/living together

Education (Check highest level): ☐ Middle/High School ☐ High School Diploma/GED ☐ Some College/Post-Secondary
☐ College Diploma / Vocational Certificate ☐ Graduate Degree ☐ Some Post-Graduate ☐Post- Graduate Degree

Primary Language _____

Religious Information

Do you have any spiritual beliefs? ☐ Yes ☐ No

What is your religious preference? Please check one of the following, if applicable:

☐ Atheist ☐ Buddhist ☐ Catholic/Christian ☐ Christian ☐ Hindu ☐ Jehovah Witness ☐ Jewish ☐ Mormon
☐ Muslim ☐ None ☐ Wicca ☐ Other _____

Do you attend a place of worship? ☐ Yes ☐ No If yes, where? _____

How did you hear about us? _____

Income Source:

☐ $0 not dependent ☐ Dependent ☐ TANF/SSI
☐ Child Support ☐ Employed ☐ Unemployed

Income Level: ☐ $0 - $14K ☐$15K - $29K ☐ $30K - $44K ☐ $44K-$59 ☐ $60K+

Place of Employment: _____

Living with:

☐ Alone or with children ☐ Spouse ☐ Mother ☐ Unknown
☐ Boyfriend/Girlfriend ☐ Friends or relatives ☐ Parents ☐ Father

Number of Biological Children: ____
Ages of children: _____ **Number in Household**____

Signature:_____ Date:_____

Life Choices Medical Clinic dba The Source

Gynecological (FEMALES ONLY)

Are your periods regular? ☐ Yes ☐ No When was the first day of your last period? _____ Normal Flow? ☐ Yes ☐ No

What is the length of your cycle? _____ (Average cycle is 28 **days between each period**) How many days do you bleed? ____

What age did your periods start? _____ Last Pap Smear: (Month/Year) _____/_____ Normal ☐ Abnormal ☐

Are you currently using any type of birth control? ☐ Yes ☐ No If yes, how long? _____

What type? ☐ birth control pill ☐ condom ☐ Depo-Provera (3 month shot) ☐ diaphragm ☐ foam / gel ☐ IUD ☐ patch

☐ Tubal Ligation / Essure ☐ vaginal ring ☐ Plan B ☐ Phexxi ☐ other: _____

Do you want to get pregnant? ☐ Yes ☐ No

Symptoms of Pregnancy: ☐ nausea ☐ vomiting ☐ dizziness ☐ fatigue ☐ swollen/tender breasts ☐ frequent urination

☐ Weight gain / loss Other: _____

If your test is positive, what are your intentions? ❑ Abortion ❑ Adoption ❑ Parent ❑ Undecided

Pregnancy History

Have you had any previous pregnancies: ☐ *Yes* ☐ *No* *Total number of pregnancies:* _____

Total abortions: _____ *Total carried to term:* _____ *Total Miscarriages:* _____

Of those pregnancies ending in abortion, did you experience any of these PHYSICAL SIDE EFFECTS? Please check all that apply.

☐ Cervical damage ☐ Hemorrhage ☐ Infection ☐ Infertility ☐ Repeated Miscarriage ☐ Ruptured uterus ☐ Scarred endometrium

Other:_____

Since your abortion(s), have you experienced any of these EMOTIONAL SIDE EFFECTS? Please check all that apply.

☐ Alcohol abuse ☐ Changed attitude toward God ☐ Drug abuse ☐ Nightmares ☐ Suicidal thoughts

☐ Anniversary Syndrome ☐ Depression ☐ Eating disorders ☐ Relationship problems ☐ Uncontrollable crying

☐ Changed attitude toward children ☐ Flashbacks ☐ Sensitivity to sound (vacuum/suction)

☐ Other: _____

How do you feel now about your abortion decision? (Check ALL that apply)

☐ Good decision ☐ Have already received post-abortion counseling ☐ Prefer not to answer ☐ Regret it ☐ Unresolved

☐ Would like help dealing with past abortion Comments: _____

Social / Abuse Information (All Patients)

Are you a victim of abuse? ☐ Yes ☐ No If so, What type? ❑ Mental/verbal ❑ Physical ❑ Sexual ❑ NA

Is this potential pregnancy the result of rape? ☐ Yes ☐ No List any medications taken in last 24 hours: _____

Are you a cigarette smoker? ☐ yes ☐ no Do you use CBD (any form)? ☐ yes ☐ no Marijuana? ☐ yes, How often? _____ ☐ no

Do you drink alcohol? ☐ yes ☐ no If so, how much? _____ ☐ Occasional ☐ <3x/week ☐ >3x/week

List any street drugs or products used in last 24 hours: _____

Caffeine? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy # of Cups/Cans per day: _____ Do you exercise? ☐ yes ☐ no

How often? ☐ 1-2 days/week ☐ 3-4 days/week ☐ 5 days or more/ week What do you do for workouts? _____

Sexually Transmitted Infection History (All Patients)

Are you concerned about an STI? ☐ Yes ☐ No Have you been tested for STI? ☐ Yes ☐ No Do you have STI? ☐ Yes ☐ No

How many sexual partners in your lifetime? _____ How many sexual partners in the last 12 months? _____

Currently Sexually active? ☐ Yes ☐ No How long have you been with your current partner? _____ Date of last sexual contact: _____

Current Sexual Partner is: ☐ Male ☐ Female ☐ Both My Sexual practices include: ☐ Vaginal ☐ Anal ☐ Oral ☐ Other

STI History (enter past infections):

☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ Herpes Type 1 ☐ Herpes Type 2 ☐ HIV ☐ Trichomonas ☐ Hepatitis B or C ☐ Mycoplasma

Month/Year of last STI Testing _____/_____ If you are experiencing symptoms, when did they start? _____

What STI symptoms are you experiencing? ☐ None ☐ Burning ☐ Cramping ☐ Discharge ☐ Odor ☐ Rash ☐ Other_____

Relationship Information (All Patients)

What is his/her relationship to you? ☐ Acquaintance ☐ Boyfriend/Girlfriend ☐ Friend ☐ Husband/wife ☐ Fiancé'

What is your partner's name (First & Last)? _____ Age? _____

Do you have any plans or hopes for a future with him/her? ☐ Yes ☐ No ☐ Unsure

Does he/she know that you might be pregnant or have STI? ☐ Yes ☐ No

If the pregnancy test is positive, will they be involved in the pregnancy decision? ☐ Yes ☐ No ☐ Unsure

Informed Consent to Telemedicine Consultation

I have been asked by my healthcare provider to take part in a telemedicine consultation with **LIFE CHOICES MEDICAL CLINIC dba THE SOURCE,** its Medical Providers, Counselors, HHSC Navigators, associates, technical assistants, and others deemed necessary to assist in my medical care through a telemedicine consultation.

I understand the following:

1. The purpose is to assess and treat my medical / other condition, obtain counseling, apply for Texas Benefits, or receive results of testing I have obtained.

2. The telemedicine consult is done through a two-way video link-up whereby the Medical Provider or other health provider at **The Source** can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the provider/counselor or other health provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit.

3. Since the telemedicine consultants practice in a different location and do not have the opportunity to meet with me face-to-face, they must rely on information provided by me or my onsite healthcare providers. **The Source** and affiliated telemedicine consultants cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.

4. I can ask questions and seek clarification of the procedures and telemedicine technology.

5. I can ask that the telemedicine exam and/or videoconference be stopped at any time.

6. I know there are potential risks with the use of this new technology. These include but are not limited to:

   - Interruption or disconnection of the audio/video link.
   - A picture that is not clear enough to meet the needs of the consultation.
   - Electronic tampering. If any of these risks occur, the procedure might need to be stopped.

7. The consultation notes may only be viewed by medical and non-medical persons for evaluation, informational, educational, quality, or technical purposes on a need to know basis.

8. I will not receive any royalties or other compensation for taking part in this telemedicine consult or associated with any use by **The Source.**

9. I understand I can make a complaint of my provider to the Texas Medical Board by going online at http://www.tmb.state.tx.us/page/place-a-complaint or calling the Complaint Hotline at 800-201-9353.

10. If this appointment is to assist in application for Health and Human Services Commission (HHSC) Benefits, I understand **The Source** is helping me to apply for benefit via the HHSC

Benefits Website. I acknowledge that The Source is acting on my behalf and not on the behalf of HHSC. I know that I DO NOT have to sign this form to apply for, get services or be approved for HHSC benefits.

11. If applying for HHSC benefits, I authorize HHSC to share facts about my case with The Source, which may include private facts about my health.

I, the undersigned patient, do hereby understand and state that I agree to the above consents. If I do not agree to any consents, I drawn a line through those items.

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand and agree to its contents. I volunteer to participate in the telemedicine examination. I authorize The Source and the Nurse Practitioners, Counselors, nurses, and other providers involved to perform procedures that may be necessary for my current medical condition.

Date: _____ Signature: _____

Interpreter (if applicable):_____ Form Expiration (one year if not specified): _____

HHSC APPLICANTS ONLY:

I confirm one of the following: (Initial one)

____ I am only sharing my personal information to complete my application or make changes to my benefits case.

____ Share my whole case record.

____ Share only the following listed facts about my case record: _____

_____

If you are signing as a legally authorized representative (defined as those persons listed below) of the person participating in the telemedicine consultation, check the phrase that best describes your authority to act for the person. Proof of this relationship may be requested.

____ A parent or legal guardian if the person is a minor.
____ A legal guardian if a judge has ruled the person is not competent to manage their own personal affairs.
____ An agent named as the person's Durable Power of Attorney for Healthcare
____ The person's court-appointed attorney ad litem
____ The person's court-appointed guardian ad litem
____ A personal representative or statutory beneficiary if the person is deceased.
____ An attorney retained by the person or by another person on this form.
____ If the person is deceased, their personal representative must be the executor, independent executor, administrator, independent administrator or temporary administrator of the estate.

Life Choices Medical Clinic dba The Source, 3234 Northwestern Drive, San Antonio, TX 78238 (210) 543-7200

General Consent for Treatment, Billing and Notice of Privacy Practices

1. CONSENT: I request and authorize healthcare services by ***Life Choices Medical Clinic dba The Source*** (Physician, Nurse Practitioner or Physicians Assistant), and his/her designees as may deem advisable. This may include electronic interfacing, routine diagnostic, radiology and laboratory procedures, medication treatment and trained counselors.
2. RELEASE OF INFORMATION: I understand that the confidentiality of all medical records will be protected according to the Health Insurance Portability & Accountability Act (HIPAA). I authorize ***Life Choices Medical Clinic dba The Source*** to release only pertinent information from my medical record to:
    a. Payors, organizations or insurance companies which are responsible, in whole or in part, for obtaining insurance benefits for me, for billing and/or paying my bill, and for filing appeals of denial of benefits, so that the medical provider may be paid for services provided to me.
    b. Independent auditors or review agencies retained by any third-party payors and insurers to analyze the charges for services rendered to me.
    c. The Source Texas for data analysis for contracts with local, state and grantor agencies.
    d. I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment, or healthcare operations. My medical providers are not required to agree to this restriction, but if they agree, they will be bound by the agreement.
3. PAYMENT: I assign and authorize payment, for any and all services rendered, directly to ***Life Choices Medical Clinic dba The Source*** from my insurance company or third party payor including but not limited to, Medicare, Medicaid, & commercial health insurance plans. In consideration of the professional services provided or to be provided to me, I agree to pay any charges not covered by my insurance or on the sliding fee schedule. Payment agreements may be authorized by the Clinic Director.
4. NOTICE OF PRIVACY PRACTICES: ***Life Choices Medical Clinic dba The Source*** has provided information about how protected health information about the patient, including information on Human Immunodeficiency Virus (HIV), AIDS Related Complex (ARC); and Acquired Immunodeficiency Syndrome (AIDS); and including substance abuse treatment records protected under the regulation ins Code 42 of Federal Regulations, Part 2, if any; and psychological and social services records, including communications made to me by a social worker or psychologist (if any) maybe used and disclosed. I have been offered an opportunity to review the NOTICE OF PRIVACY PRACTICES before signing this form. I understand the terms of the notice may change and that I may obtain a revised copy by requesting it on site at ***Life Choices Medical Clinic dba The Source.*** By signing this form, I acknowledge that I have been offered and/or received the NOTICE OF PRIVACY PRACTICES of ***Life Choices Medical Clinic dba The Source.***
5. As a Non-Profit organization, ***Life Choices Medical Clinic dba The Source,*** utilizes medical, professional and peer volunteers for many of the services offered. I understand that legal action cannot be taken against any volunteer who renders services at ***Life Choices Medical Clinic dba The Source.***
6. It is the policy of ***Life Choices Medical Clinic dba The Source*** to report all positive sexually transmitted infections required by the State of Texas and applicable counties to the Texas State Department of Health or appropriate county entity that is specified in the Health & Human Services Code. Results are given in person, via the secure patient portal, or after verified identity requested by appropriate licensed professionals.

I have read the consent form or it has been read to me & I am satisfied that I understand its contents. My questions have been answered to my satisfaction.

Printed Name Signature Date

REVISED & UPDATED: NOVEMBER 2020