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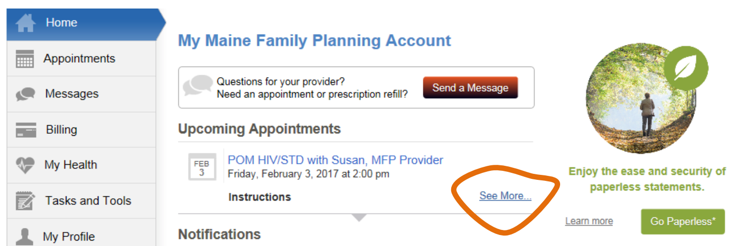
www.maineteenhealth.org

We're so glad you will be coming soon for a visit to start or continue your trans journey.

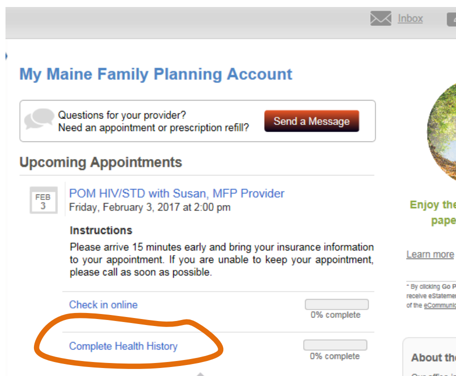
We'd just like to give you the opportunity to save time at your first visit by filling out some of the paperwork ahead of time.

Included in these documents are:

- Estimated charges:
    - just FYI if you don't have insurance or your insurance doesn't pay. We do have a sliding fee scale available for your visits. Lab charges on here are estimates for people with no insurance based on the prices at Nordx labs.
- Patient history form:
    - The easiest for all is if you go onto your portal account and fill out your health history home your home page.
    - You will see your appointment time. Click "See more" to start doing your history.



    - Once there, you can click on "Complete Health History"



Unfortunately, our Electronic Medical Record system only has male and female for options for sex. Please put your "legal" sex on that question. We ask more politically correct gender questions on the medical history. Sorry, we have no control over this.

    - If you can't do your history on line, please do it in paper and bring it in with you.

Please fill out ahead of time and bring in with you to the visit.

- Registration form
- Assignment and release for Open Door

And don't forget your medical insurance card if you have insurance.

If you are already on hormonal treatment, please bring the bottles/vials.

Thanks and look forward to seeing you soon.

First Year Open Door Project
Estimated Costs of Services, Labs and Medications *if insurance isn't used*

Office Visits-Every 3 months (sliding scale available)	Lab Work-Every 3 months NorDx estimated charges *reduced fees if paid at time of service. Sliding fee scale available for lab work.	Medications
1st Visit-Consultation $43-$215 Follow-up Visits $25-$122 3 month checkup 6 month checkup Annual Exam 6 months after Annual Exam	CBC .... $23 Hepatic .... $18*-$22 Lipid .... $31*-$39 HGBA1C .... $23*-$30 CMP.................. $21*-$27- Comprehensive Metabolic Panel (includes Glucose, lytes, and liver) Estradiol........... $91 (M-F) if needed Prolactin........... $50*-$64 (M-F) Testosterone..... $68*-$160 if needed (F-M & M-F) Labs can be ordered at the lab of the patient's choice. Nordx is much more reasonably priced for people with a high deductible or no insurance and they have a patient assistance program you can apply to for a reduction in fees. See http://www.nordx.org/insurance_changes.html and look under charity care for more info and application.	**M-F** **Spironolactone 100 mg:** good rx coupon $16 & up for 90 **Spironolactone 25 mg:** $10 for 90 at Walmart **Estradiol** Walmart: 0.5 mg/1 mg/2 mg $4/#30; $10/#90 RiteAid: 0.5 mg/1 mg/2 mg $10/#30 **Estradiol Transderm patches** Walmart: mg/day wkly patch #4 $38-50 RiteAid: mg/day wkly patch #4 $75 **Estradiol gel 40 pumps/can (about 2 wks worth)** Walmart: 50 gm $133 **Depo estradiol injectable**- Good rx coupon $98 and up for 5 ml vial **F-M** **testosterone cypionate with Goodrx coupon:** prices start at $45 for 10 ml and going up. **RiteAid:** 1 ml/vial of 200 mg/ml/$28 (plus the cost of syringes) **Androderm Patch** RiteAid: 2 mg/day/30 patches/$489 4 mg/day/30 patches/$489 Walmart: 4mg/day/30 patches $509 **Androderm gel** Walmart: 25 mg 60 pumps/can $254 50 mg 60 pumps /can $151 **Axiron underarm gel** Walmart: $540 ………………………………………………………. *These prices are estimates according to our research in 11/15. Prices will vary. Shopping around is a good idea.* ➢ *Discount coupons are available at goodrx.com. These are definitely worth checking as they can be substantial discounts.*

ASSIGNMENT AND RELEASE FOR OPEN DOOR HEALTH CARE

If you have medical insurance, please review and sign the following statement:

- My signature below authorizes Maine Family Planning to bill my insurance and receive payment from them for services given to me by Maine Family Planning.
- I understand that I am financially responsible for all charges not paid by insurance.
- I authorize the use of this signature on all my insurance submissions.
- I authorize the Maine Family Planning to release my health care information, to the extent necessary, to my insurance carriers and their reviewers or others paying for this care.
- **Charges for the labwork ordered by us will be billed by the lab to my private insurance, Medicaid/Medicare but if there is a remaining amount after insurance processing, I will be billed directly by the lab and that I am responsible for these charges.**
- I agree to pay any insurance co-pays at the time of service. I acknowledge that I am responsible for deductibles, coinsurance and charges not covered by insurance and those charges must be paid in full within 30 days or by my next appointment, whichever is sooner.
- I understand that for Medicaid, Medicare or Private Insurance to be billed, I **MUST** present a current insurance card at every visit.

____ Initials

- Name of Policy Holder ______________________________________
- Relationship to Policy Holder _________________________________

If you don't have medical insurance:

- I understand that payment for services at Maine Family Planning is due in full at time of service.
- **I understand that all lab orders can be sent to a lab of my choice and I will be billed directly by them for any testing and that I am responsible for those charges.**

____ Initials

Everyone, please sign below:

Acknowledgement of receipt of Notice of Health Information Privacy Policies

- I hereby acknowledge that I have been given/offered the Maine Family Planning NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES.
- (Optional): I request that the following covered entities not have access to my private health care information without my written consent:

____

Signature: _____________________________________ Print Name: ___________________________________

Date: ____/____/_____

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Client Registration

Name:________________________________ I prefer to be called:_______________ Date of Birth:____/____/_____
Phone #:________________________ Work/School #__________________ Cell phone #:______________________
Mailing Address: Street______________________________ City_________________ State_______ Zip__________
Social security #:________-_______-__________ Email: print clearly, please______________________________
❒ Male ❒ Female ❒ Transgender ❒ Other_______________
Do you have Medical Insurance?❒Yes❒No Are you planning to use your insurance today?❒Yes❒No If not, why?________________
If you are using your insurance today, what type: ❒ Medicaid ❒ Other:___________________
Please present your card to the receptionist.

Please check all the ways that we may contact you:
❒ Call home ❒ Call work ❒ Call cell phone ❒ Send mail ❒ Email ❒ Text me
Is it okay to say "Family Planning" is calling if we need to contact you? ❒ Yes ❒ No
***I understand it is my responsibility to inform you of any changes in my address or phone information.**
In case we need to contact you and are unable to reach you, who could we contact to ask them to ask you to contact us?
(We would not discuss the reason we need to contact you)
Alternative Contact Person_________________________ Phone____________________ Relationship_____________
Special contact instructions:____

Please answer the following questions for statistical reasons:
How did you hear about us? ❒ Hospital ❒ Other Medical Provider ❒ Friend/family ❒ Internet ❒ Other___________
Marital Status ❒ Single ❒ Married ❒ Divorced ❒ Widow ❒ Partnered
Are we your primary source of health care? ❒ Yes ❒ No
Race (check all that apply) ❒ White ❒ Black ❒ American Indian/Alaskan ❒ Asian ❒ Hawaiian/Pacific Islander
Hispanic/Latino ❒ Yes ❒ No **Primary Language**:_________________

Consent to Obtain Medication History:

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time discuss everything you are taking, and for you to point out to us any errors in your medication history.

❒ I give permission for you to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.
❒ I do not give permission for you to obtain this information at this time.

Patient Signature____ Today's Date____________________

maine family planning

Health History

Name: ______________________________ ***Date of Birth:*** ______________________

- Which pharmacy do you usually use for prescriptions? ______________________ Location? ________________
- Do you have another health care provider besides us? ❒ no ❒ If yes, who: ____________________________

Medication allergies: ❒ no known med allergies	Med allergy # 1	Med allergy # 2	Med allergy # 3	Med allergy # 4	Med allergy # 5
Reaction to that medication:					
Other allergies:					

- What medications do you take regularly?

Medication/vitamin/supplement	Dose/strength (ie mg/pill)	How many times a day

Vaccinations

- **Hepatitis B vaccine**

  ❒ All done ❒ had part of series ❒ have not had ❒ don't know ❒ might be interested
- **HPV vaccine** (Gardasil/Cervarix) for people under 27 yrs old

  ❒ All done ❒ had part of series ❒ have not had ❒ don't know ❒ might be interested

Family History:
Who in your family has any of these problems and at what age did they get it if you know.

	Mo	Fa	Sis	Bro	Kids		Mo	Fa	Sis	Bro	Kids
Has no health problems	Age	Age	Age	Age	Age	Stroke	Age	Age	Age	Age	Age
Blood clotting disorder	Age	Age	Age	Age	Age	High cholesterol	Age	Age	Age	Age	Age
Bleeding too easily	Age	Age	Age	Age	Age	High blood pressure	Age	Age	Age	Age	Age
Cancer: type	Age	Age	Age	Age	Age	Mental health probs.	Age	Age	Age	Age	Age
Diabetes	Age	Age	Age	Age	Age	Thyroid problems	Age	Age	Age	Age	Age
Heart attack	Age	Age	Age	Age	Age	Other major health probs.	Age	Age	Age	Age	Age

About you, your family, your life

By what name would you like to be called? ____________________

Personal pronouns to describe yourself: .... ❒ she, her, hers ❒ he, him, his ❒ they, them, theirs Other: __________

What sex were you assigned at birth? .... ❒female ❒ male

What is your current gender? .... ❒female ❒ male ❒ Transwoman/transfemale ❒ Transman/trans male

❒ Genderqueer/gender non-conforming ❒ Intersex ❒ other: __________

Your occupation________________________

In school now? .... ❒ yes ❒ no Highest grade completed ___

Are you: .... ❒ single ❒ married ❒ divorced ❒ separated ❒ widowed ❒domestic partner

Number of children: _____ Ages: __________

Whom do you live with? .... ❒ parents ❒ partner /spouse ❒ at school ❒ friends ❒ on your own ❒ your kids

❒ couch surfing ❒ in a shelter ❒ homeless ❒ other, ________

Interests/Hobbies:______________________

Life going well in general for you? .... ❒ yes ❒ no

Do you need any help from us in finding help or counseling for any problems or issues? ❒ yes ❒ no

About your habits

Tobacco use-ever .... ❒ Smoker ❒ chewer? ❒ now ❒ past ❒ never If now, how much?____ For how long?__________

Want help quitting? ❒ yes ❒ no

Usual alcohol use.......................... ______ drinks a day _____ drinks a week

About your sexual history

How do you describe your sexual orientation?............ ❒ Straight ❒ Gay/Lesbian ❒ Bisexual ❒Asexual ❒Other

Are you attracted to: (check all that apply) .... ❒ men ❒ women ❒ both/all ❒ other____________

Ever had sex? ❒ no ❒ yes , If yes, how many sexual partners have you ever had? ___ Were they ❒ male ❒female ❒ transgender ❒ other

Teens under 18... About your parents...

If you are having sex, do they know? ....❒ no ❒ yes Do they know you are coming to clinic? ❒ no ❒ yes

Can you talk to them about personal things in your life? .... ❒ no ❒ yes

Contraception

What if, anything, are you using or doing to prevent pregnancy when you have sex? ❒ I am on a birth control method ______________

❒ my partner uses birth control ❒ condoms ❒ withdrawal ❒ tubal ligation (tubes tied) ❒ vasectomy

❒ trying for pregnancy ❒ not using anything ❒ my partners are the same sex ❒ not having sex

Interested in a different birth control? ❒ No ❒ Maybe ❒ Yes, I want_____________________

Surgeries: ____❒ none

Females

First day of your last period	Your age at your first period	Age of first intercourse	# of Pregnancies	# of Births	# of Miscarriages	# of Abortions	# of Living Children	Date when last pregnancy ended

Have you been pregnant since your last visit with us? ❒ no ❒ yes Now breast feeding? ❒ no ❒ yes

Date of last pap test: __________ It was ❒ normal ❒ abnormal. Have you ever had any other abnormal pap tests? ❒ no ❒ yes

If menopausal, when was your last period? ________

Health History: Please check off any of these that apply to you now or in the past.

❒ Headaches: ❒ frequent ❒ severe ❒ migraines
❒ Headaches with sparkles, spots or vision changes
❒ Epilepsy/seizures ❒ serious brain injury

❒ Diabetes ❒ osteoporosis
❒ Thyroid lump/enlargement or ❒ overactive ❒ underactive thyroid

❒ Heart attack ❒ murmur ❒ other heart problems
❒ High blood pressure ❒ high cholesterol
❒ Bleeding disorder ❒ blood clotting disorder (not related to periods)
❒ Blood clot in ❒ lung ❒ leg ❒ brain/stroke
❒ Varicose veins ❒ anemia

❒ Asthma or ❒ other lung problems

❒ Stomach ❒ intestinal problems ❒ gall bladder problems
❒ Hepatitis or other liver problems ❒ colonoscopy (date) ________

❒ Bladder infec/UTI ❒ incontinence ❒ other bladder/kidney probs
❒ Chlamydia ❒ gonorrhea ❒ genital warts/HPV
❒ Herpes ❒ syphilis ❒ HIV/AIDS

Mental health problems: ❒ anxiety disorder ❒ depression
❒ bipolar ❒ other mental health probs: _______________
❒ tried or seriously considered suicide ❒ recently ❒ in past

❒ Eating disorder ❒ extreme exercising ❒ non prescribed steroid use
Significant weight ❒ gain ❒ loss

❒ Fibromyalgia
❒ Birth defects ❒ genetic/inherited disease
❒ Cancer, type: when?

RISKS
❒ Had sex for money drugs or safety
❒ Had sex with someone with HIV/AIDS ❒ hepatitis B/C
❒ Substance abuse problems ❒ alcohol ❒ other
❒ Shared needles ❒ Had a partner who did

FEMALES
Mammogram Approx. date: last______ ❒ Abnormal mammo ________
❒ Breast lump ❒ breast discharge ❒ breast cancer
❒ Fibroids/uterine growths ❒ frequent vaginal infections
❒ GYN Surgery ❒ have problems with pelvic exams
❒ Chronic pelvic pain ❒ endometriosis
❒ Ovarian: ❒ cysts ❒ cancer
❒ PCOS (polycystic ovaries) ❒ other problems with ovaries
❒ Pelvic infection/PID ❒ toxic shock
❒ Infertility/problems getting pregnant

MALE
❒ Prostate problems ❒ NGU (infection in urethra)
❒ Infertility problems # of children you have fathered ____

❒ None of these above items apply to me

Other serious injuries, illnesses: _______________________________

√ If you...

❒ Are now afraid of your partner or anyone else? Need help dealing with this? ❒ yes ❒ no

❒ Have been hit, slapped, kicked or otherwise physically hurt in the past year? Need help dealing with this? ❒ yes ❒ no

❒ Have ever been emotionally abused by someone close to you? Causing you problems now? ❒ yes ❒ no

❒ Have been forced to have sex or sexually abused? Causing you problems now? ❒ yes ❒ no