Name:_____ DOB:_____ Age:_____ Today's Date:_____

Pharmacy name, location, phone number:_____

Primary Care Physician: _____ Main reason for today's visit:_____

Allergies (and your reactions to them)-

Current Medications- Please list prescription medications/vitamins + dosage:

Please list any new medical problems, surgeries, or family history since your last visit:

Have you had all 3 Gardasil shots?_____

Birth control method:_____

Date of last menstrual period:_____

Date of last pap smear + result:_____

Date of last mammogram + result: _____

Date of last bone density scan + result:_____

Date of last colonoscopy scan + result:_____

Date of last flu vaccine:_____

Total # of pregnancies: _____

Total # of living children: _____

SOCIAL HISTORY:

SMOKING	Used to	Currently
# packs per day		
# of years smoking		
Did you quit? When?		

DRINKING	Used to	Currently
# of occasions/week		
# drinks in one day		
MOST # in one day		
Did you quit? When?		

RECREATIONAL DRUGS *yes*__ *no*__

Do you, or have you ever used recreational drugs? *If yes, specify which + frequency:*

Are you employed? *yes*__ *no*__

Occupation: _____

Are you a victim of domestic violence? *yes*__ *no*__

Relationship status: _____

Do you exercise? *yes*__ *no*__ What kind? _____ How often? _____

Who currently lives with you? _____

Any changes in home/work life? _____

Please circle any of the following conditions you are currently experiencing:

NEUROLOGICAL
- Headaches
- Memory problems
- Numbness/tingling
- Seizure disorder
- Blurred vision

HEMO/LYMPH
- Bruising/bleeding
- Anemia
- Swollen lymph nodes
- Sickle cell disease or trait
- Bleeding disorder

URINARY
- Urination frequency
- Pain with urination
- Leaking of urine
- Bloody urine
- UTI

ENT
- Hearing loss
- Hearing problems
- Congestion
- Sore throat

PSYCH
- Depression
- Crying spells
- Suicide attempt
- Eating disorder
- Psychiatric disorder

EYES
- Vision changes
- Double vision
- Glasses

ENDO
- Cold intolerance
- Thyroid problems

RESPIRATORY
- Shortness of breath
- Chronic cough
- Coughing up blood
- Asthma
- Tuberculosis
- Difficulty/painful breathing

CARDIOVASCULAR
- Chest pain
- Irregular heart beat
- Swollen legs
- Heart disease

GASTROINTESTINAL
- Bloody stool
- Nausea/vomiting
- Diarrhea
- Constipation

CONSTITUTIONAL
- Weight loss
- Weight gain
- Fever
- Fatigue

MUSCULOSKELETAL
- Muscle/joint pain
- Swelling of joints
- Bone loss

SKIN
- Itching
- Burning
- Rash

REPRODUCTIVE
- Irregular menses
- Menopause
- Sexual dysfunction

Office use only- Ht:_____ Wt:_____ BP:_____ Temp:_____

FIRST POINT OF CONTACT SCREENING

Name: _____ Date: _____

We are committed to providing the safest environment for our patients and together we can prevent the spread of germs.

Please complete the questionnaire below. If you answer yes to any of the questions, please be considerate of others and act appropriately such as covering your cough, washing our hands, and covering any open wounds.

For the protection of our patients, we gladly supply and encourage the use of tissues, masks, hand sanitizer, and Band Aids.

1. Do you have any of the following symptoms? ☐YES ☐NO
   Please circle any symptoms you have now, or have had over the past seven days:
   - ☐ - Fever
   - ☐ - Night sweats
   - ☐ - Sneezing or runny nose
   - ☐ - Cough
   - ☐ - Severe headache
   - ☐ - Stiff neck
   - ☐ - Muscle or joint pain (circle one or both)
   - ☐ - New rashes or open sores on your skin or in your mouth
   - ☐ - Redness, swelling, or discharge of your eyes (pink eye)
   - ☐ - Unexplained bleeding
   - ☐ - Vomiting or diarrhea
2. In the past three weeks, have you traveled outside the United States? ☐YES ☐NO
   If yes, please list where: _____
3. In the past three weeks, have you had close contact with someone who has traveled outside the United States? ☐YES ☐NO
   If yes, please list where: _____

Thank you for your help and support in caring for our patients and community.

To be filled out by office staff:
Reviewed by: _____
Action taken:
- ☐ *No action taken*
- ☐ *Isolate*
- ☐ *Cough/hand washing etiquette provided*
- ☐ *PM/Lead clinical notified*

Thank you for trusting us with your healthcare!

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practice/clinics

_____ **(Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Practice:OPTIONAL ON FORM- REMOVE THIS Prescription Order Pick up Section **ONLY** if NA to your practice/clinic

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

Name: _____
Date of birth: _____

Patient Consent for Financial Communications

Insurance issues, requirements and coverage are ever changing. We are making every effort to be in compliance and to eliminate payment denials before they occur. Your insurance plan *may or may not* cover routine preventative services, including lab testing.

We are legally obligated to assign procedure codes based on the service provided to you, whether it is a wellness exam. A visit to take care of problems, or both. *We cannot change the coding later to cause the insurance company to pay for a non-covered service.*

Based on the kind of coverage you have, some or all of this cost may have to be billed to you. Your insurance may apply the charges to your deductible or coinsurance and you will be responsible for any patient balances remaining.

Please keep in mind that while the appointment may be just for a physical or just for problems, if both kinds of services are provided during a visit, then both services may be billed. *If both services are billed, you may be responsible for pay a co-payment for each service, depending on your insurance coverage.*

Financial Agreement:

- I acknowledge, that as a courtesy, CONSULTANTS IN OBGYN may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection: I acknowledge CONSULTANTS IN OBGYN may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits: I hereby assign to CONSULTANTS IN OBGYN any insurance or other third-party benefits available for health care services provided to me. I understand CONSULTANTS IN OBGYN has the rights to refuse or accept assignment of such benefits. If these benefits are not assigned to CONSULTANTS IN OBGYN, I agree to forward all health insurance or third-party payments I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification & Assignment of Benefit: I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to CONSULTANTS IN OBGYN by the Medicare or Medicaid program.

Consent to Calls for Financial Communications: I agree that, in order for CONSULTANTS IN OBGYN or Extended Business Office (EBO) Servicers to collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that CONSULTANTS IN OBGYN or EBO Servicer and collection agents may contact me by telephone number, without limitations of wireless, I have provided CONSULTANTS IN OBGYN or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding services rendered, or my financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable.

We thank you for taking the time to complete this form. We are making every effort to comply with governmental rules and the rules of all insurance plans for claims submissions. We appreciate the help of our patients in this endeavor.

A photocopy of this consent shall be considered valid as the original.

Patient/patient representative signature: _____ **Date:** _____

If you are not the patient, please identify your relationship to the patient. Circle or make relationship(s) below:

- ☐ Spouse
- ☐ Parent
- ☐ Legal Guardian
- ☐ Guarantor
- ☐ Healthcare Power of Attorney
- ☐ Other (please specify) - _____

Surprise Billing – Know Your Rights

Beginning January 1, 2020, Colorado state law protects you from "Surprise Billing," also known as "Balance Billing." These protections apply when:

- ***You have a Colorado Department of Insurance (CO-DOI) designation on your health insurance ID card, and***
- **You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or**
- **You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado.**

What is surprise/balance billing, and when does it happen?

If you are seen by a provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network", you may receive a bill for additional costs associated with that care. Out-of-network facilities or agencies often bill you the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you cannot be balance-billed, emergency services

If you are receiving emergency services, the most you can be billed is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be billed for any other amount. This includes both the facility where you receive emergency services and any provider's that see you for emergency services. Please note that not every service provided in an emergency department is an emergency service.

Non-emergency services at an in-network facility by an out-of-network provider

The facility or agency must tell you, based on the insurance information you provide, if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by an out-of-network provider.

You have the right to request that in-network providers perform all covered medical services and the facility will attempt to accommodate if the facility has this information. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for covered services is your in-network cost-sharing amount which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional protections

Your insurer will pay out-of-network providers and facilities directly.

- **Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.**
- **Your provider, facility, hospital, or agency must refund any amount you overpay within 60 days of being notified.**
- **No one, including a provider, hospital, or insurer, can ask you to limit or give up these rights.**

If you receive services from an out-of-network provider, or facility or agency in any other situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance billed.

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the Billing Department at 888-422-7720, or the Colorado Division of Insurance at 303-894-7499 or 800-930-3745.

Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.

Patient Care Expectations

We would like to welcome you to our office for your OB/GYN healthcare needs, and we look forward to the relationship we will develop in the years to come. This will give you some guidance about what you can expect here at Consultants in OB/GYN.

Patient Portal

The patient portal is designed to improve the timeliness and quality of our communication with you. We highly recommend that you sign up for the portal.

The portal will allow you to:

- Request non-urgent medical advice
- Schedule appointments
- Obtain visit summaries
- Order medication refills
- View lab results

Download on the App Store Get it on Google play healow

If you have provided our office with an email address, you will automatically be enrolled in this exciting feature however, you must login to complete your enrollment. You must register within 24 hours of receiving the email with directions. Please follow the directions in the email, you cannot use a mobile phone to sign up and contact our office with any questions. There is also a mobile app called HEALOW or HEALOW MOM available to download for free that gives you access to the above portal functions through your phone.

Leaving a Message

Our entire office staff is trained to be confidential and compassionate in meeting the needs of our patients. The more information you can give to whomever is taking your message, the better and faster we can assist you.

- For your safety, please direct all URGENT messages to the Front Desk staff and not on a voicemail. Urgent messages will be returned by end of business day.
- Please use the patient portal for all non-urgent messages ONLY.
- If you have left a non-urgent message for the Medical Assistant or Care Coordinator, calls will be returned within 1 business day.

Medication Refills

- All medication refill requests should be initiated with your pharmacy. To accurately monitor your medications, requests are processed through our electronic medical record by your pharmacy.
- Please allow 48-72 business hours to refill your medication and 2 weeks for mail order pharmacies.
- Did you know that you can also request medication refills through the patient portal? Sign up today!

Imaging, Labs or Procedure Testing Orders and Results

- Orders for imaging sent to outside imaging facilities may take 1-2 business days to be faxed over. Please allow time before calling that facility for scheduling. Call our office if the facility reports that it does not have an order for the planned imaging test.
- The imaging centers that are utilized by our office are responsible for prior authorizations. Once your study has been approved by your insurance company, the imaging center will reach out to you for scheduling.
- If your results are **normal or unchanged**, you will receive the results and a message from your provider electronically via the Patient Portal.

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Fax: 303-322-9260

- If your results are **abnormal and/or require further testing**, a member of our team will call you to discuss the results in addition to sending the results and a message to the Patient Portal.
    - Most lab work is reviewed **within 5 business days** by your physician. If you do not see your results posted to the Patient Portal and/or have not received a letter or a call from us **2 weeks** after the blood work has been drawn, please call our office.
    - Ultrasound results , X-rays, MRIs, and CT scans can be expected in 7-10 days
    - PAP smear results can be expected in 10-14 days
    - Mammogram and Bone Density results are sent to you from the facility where you have it performed.

REFERRALS AND PRIOR AUTHORIZATIONS

Referrals may take up to 2 business days to process. Please allow the specialist's office 5 business days to contact you to schedule. If you do not hear from them after this time, please contact our office to and we will send the referral again.

APPOINTMENT SCHEDULING

- Please call our office or email us using the patient portal to make an appointment.
- We ask that you notify our office by phone at least 1 business day prior to your appointment if you are not able to make your scheduled visit. Missed appointments or same-day cancellations may result in dismissal from the practice.
- If you are more than 15 minutes late for an appointment, you may need to reschedule.
- Please note that we care for urgent/emergent patients and your appointment may need to be rescheduled. We will notify you ASAP if we need to reschedule your appointment. Make sure we have your correct contact information and your voice mailbox is available.

SURGERY SCHEDULING

- If you have discussed having a surgery with your provider, our surgery scheduler will contact you after she receives the order from your physician.
- Please remember:
    - **No food or drinks after midnight prior to your surgery.**
    - **You MUST have a ride home after surgery. Taxi, Uber, Lyft, and other types of rides home are not permitted.**
    - **You will get a call from the hospital/facility pre-procedure and registration department.**
- Your first postop appointment will be approximately two weeks after surgery.
- Please do not hesitate to contact our office with any questions or concerns regarding your surgery.
- Please note that we care for urgent/emergent patients and your surgery may need to be rescheduled. We will notify you ASAP if we need to reschedule your surgery.

PATIENT EXPERIENCE SURVEY

Exceptional patient care, dignity and respect is our standard, and we ask for the same consideration in return. We kindly ask for a few minutes of your time to take our survey after your visit.

- A survey will be emailed to you within 24 hours after your visit.
- If we do not meet this standard, please let us know prior to leaving the office by asking to speak with our manager.
- Our office loves to hear from our patients in order to improve their experience, we greatly appreciate feedback.

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