PATIENT QUESTIONNAIRE

Patient Information

Patient name:_____ Date of Birth: _____ Age:____ Primary Care Physician:_____

Today's date: _____ Main reason for today's visit: _____

Were you referred by a doctor? If so, by who? _____ How did you hear about us? _____

Do you have a religious preference? _____ What is your race or ethnic background? _____

Pharmacy name, location, phone number: _____

Medications: List all prescription medications and vitamins you currently take, along with their dosages:

Allergies: List all allergies you have, along with your reaction to them:

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 # of drinks in one day		
Did you quit? When?		
USE OF RECREATIONAL DRUGS		
Do you / have you ever used drugs recreationally? *yes*___ *no*___ *If yes, list which + frequency:*		

Are you employed? *yes*___ *no*___

Occupation: _____

Any changes in home/work life recently? _____

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

Who currently lives with you?_____

Relationship status: _____

Do you exercise? *yes*___ *no*___

If yes, what kind? _____ How often? _____

If you **HAVE NOT** gone through menopause:
Date of last period:
How often do they come?
How many days do they last?
Flow: light, moderate, or heavy?
Any pain with periods?

GYN History:

Last pap smear *date + result*:_____

Have you ever had an abnormal pap result? *yes*__ *no*__

*If yes, date and treatment:*_____

Birth control method:_____

Have you used a different method of birth control in the past? *yes*__ *no*__

If yes, please specify: _____

Last colonoscopy *date + result*:_____

Last bone density scan *date + result*:_____

Last mammogram *date + result*: _____

Date of last menstrual period:_____

Date of last flu shot: _____

Have you gotten all 3 Gardasil shots? *yes*__ *no*__

Sexual orientation: Heterosexual | Bisexual | Homosexual | Other

At what age did you start menstruation?_____

Have you ever been diagnosed or treated for:

Infertility *yes*___ *no*___ Ovarian cysts *yes*___ *no*___

Fibroids *yes*___ *no*___ Endometriosis *yes*___ *no*___

Indicate which of the following conditions you have a history of:

If yes, list what treatment you received.

*yes*___ *no*___ Gonorrhea_____

*yes*___ *no*___ Genital warts _____

*yes*___ *no*___ Chlamydia _____

*yes*___ *no*___ Syphilis _____

*yes*___ *no*___ Herpes (specify genital or non-genital)_____

*yes*___ *no*___ Pelvic inflammatory disease _____

*yes*___ *no*___ HIV _____

If you **HAVE** gone through menopause:
When did you stop having periods?
Have you ever been evaluated for bleeding after menopause?
Have you ever taken hormone replacement therapy?

Circle any of the following conditions you are currently experiencing:

NEUROLOGICAL
- ☐ Headaches
- ☐ Memory problems
- ☐ Numbness/tingling
- ☐ Seizures
- ☐ Blurred vision

RESPIRATORY
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Difficulty/pain breathing

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

CONSTITUTIONAL
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fever
- ☐ Fatigue

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

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

SKIN
- ☐ Itching
- ☐ Burning
- ☐ Rash

PSYCH
- ☐ Depression
- ☐ Crying spells

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

HEMO/LYMPH
- ☐ Bruising/bleeding
- ☐ Anemia
- ☐ Swollen lymph nodes

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Swollen legs

EYES
- ☐ Vision changes
- ☐ Double vision
- ☐ Glasses

REPRODUCTIVE
- ☐ Irregular menses
- ☐ Menopause
- ☐ Sexual dysfunction

ENDO
- ☐ Cold intolerance
- ☐ Thyroid problems

Main reason for today's visit: _____

Patient & Family Medical History: Indicate ONLY the conditions you currently have, have had in the past, and those of which you have a family history of.

Your current issue? *Yes/No*	Your past issue? *Yes/No*	Condition	Family history? *Yes/No*	*If YES:* Family member alive or deceased? + relation (indicate maternal or paternal) + age
		Diabetes		
		Hypertension		
		High cholesterol		
		Bone loss		
		Autoimmune disorder		
		Epilepsy/Seizure disorder		
		Hepatitis/Liver disease		
		Migraines		
		Kidney disease		
		UTIs		
		Asthma		
		Heart disease		
		Blood clots in lungs		
		Psychiatric disorders		
		AIDS		
		Trauma or violence		
		Sickle cell trait/disease		
		Anemia		
		Bleeding disorder		
		Tuberculosis		
		Vascular/thromboembolic		
		Thalassemia		
		Thyroid dysfunction		
		Depression		
		Stroke		
		Heart attack		
		Down Syndrome		
		Congenital heart defects		
		Neural tube defects		
		Hydrocephalus		
		Muscular dystrophy		
		Developmental delay		
		Cystic fibrosis		
		Osteoporosis		
		Cleft palate or lip		
		Infertility or DES		
		Deafness		
		Blindness		
		Hemophilia		
		Breast cancer		
		Colon cancer		
		Ovarian cancer		
		Uterine cancer		
		Other cancer		

Patient OB/Pregnancy History

Total # of pregnancies_____ Total # of living children: _____

Deliveries:

Date	Weeks at delivery	Labor time (hrs)	Birth weight	Sex of baby	Route of delivery	Anesthesia: natural, IV, epidural, etc	Hospital	Child OK (x if no)	Premature labor (x if yes)

Hospital + Surgical History:

Have you ever received a blood transfusion? *yes*___ *no*___

Have you ever been hospitalized overnight? If so, for what?

Have you ever had surgery? List all surgeries and biopsies, along with their dates:

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 REGISTRATION FORM (eCW)

PATIENT INFORMATION

(Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline):_____Cell:_____Work: _____

E-Mail Address:_____Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose
☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc
☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian
☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_____

Patient Social Security Number:___-_____-_____ Would you like to be enabled with our patient portal? Yes ☐ No ☐

RESPONSIBLE PARTY INFORMATION (*If not self*)

(Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐
Responsible party name: (Last)_____(First)_____(MI) _____
Date of birth: MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male
Responsible Party Social Security Number:_____-_____-_____Phone number: _____
Address:_____
City, State:_____ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____
Phone number:_____ Do you have a living will? ☐ Yes ☐ No
Emergency contact relationship to patient:_____ ☐ Guardian
Address_____
City, State:_____ZIP: _____
Home phone:_____Work phone:_____Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding ânу test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____Date: _____

Printed name of patient or personal representative:_____Relationship to patient: _____

Primary care physician information:

Name: _____ Phone number: _____

Address: _____

Pharmacy information:

Name: _____ Phone number: _____

Address: _____

How did you hear about us? Circle any that apply:

☐ Website ☐ Family/Friend ☐ Internet Search

☐ Former or current patient (please provide name so we can thank them!) _____

☐ Physician (please specify): _____

☐ Other Healthcare facility (please specify): _____

☐ Insurance network (please specify): _____

☐ Other (specify): _____

Consultants in Obstetrics and Gynecology

NO SHOW POLICY

Our goal here at Consultants in Obstetrics and Gynecology is to provide quality service to our patients. Failure to keep scheduled appointments is costly to the practice, yourself and other patients. This notice is to inform you of our policy concerning "No Shows".

Patients who are not able to keep their appointments are asked to cancel within a 48 hour period prior to their appointment. We realize that it is not able to be done sue to unforeseen circumstances and we will consider that on a case by case basis. Providing this notice gives us the opportunity to work in other patients who are needing to be seen this utilizing the practice's time in a wise manner. If any patient cancels or no shows for his/her appointment 3 times in a row they will be considered dismissed from the practice and a dismissal letter will be sent. If a new patient no-shows for their appointment, they will not be allowed to schedule any future appointments with this practice.

I have read this policy and understand the details within it and accept the terms.

_____ _____

Patient Signature Date

Patient Rights and Responsibilities

Patient Rights

We respect the dignity and pride of each individual we serve. We comply with applicable Federal civil rights laws and do not discriminate on the basis of age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law. Each individual shall be informed of the patient's rights and responsibilities in advance of administering or discontinuing patient care. We adopt and affirm as policy the following rights of patient/clients who receive services from our facility:

Considerate and Respectful Care

- To receive **ethical, high-quality, safe** and **professional** care without discrimination
- To be free from **all** forms of **abuse and harassment**
- To be treated with **consideration, respect** and **recognition** of their individuality, including the need for privacy in treatment. This includes the right to request the facility provide a person of one's own gender to be present during certain parts of physical examinations, treatments or procedures performed by a health professional of the opposite sex, except in emergencies, and the right not to remain undressed any longer than is required for accomplishing the medical purpose for which the patient was asked to undress

Information Regarding Health Status and Care

- To be **informed of his/her health status** in terms that patient can reasonably be expected to understand, and to participate in the development and the implementation of his/her plan of care and treatment
- The right to be informed of the **names and functions** of all physicians and other health care professionals who are providing direct care to the patient
- The right to be informed about any **continuing health care requirements** after his/her discharge from the hospital. The patient shall also have the right to receive assistance from the physician and appropriate hospital staff in arranging for required follow-up care after discharge.
- To be informed of **risks, benefits and side effects** of all medications and treatment procedures, particularly those considered innovative or experimental
- To be informed of all appropriate **alternative treatment procedures**
- To be informed of the **outcomes** of care, treatment and services
- To appropriate assessment and **management of pain**
- To be informed if the hospital has authorized **other health care and/or education institutions** to participate in the patient's treatment. The patient shall also have a right to know the identity and function of these institutions, and may refuse to allow their participation in his/her treatment

Decision Making and Notification

- To choose a person to be **his/her healthcare representative and/or decision maker**. The patient may also exercise his/her right to exclude any family members from participating in his/her healthcare decisions.
- To have a family member, chosen representative and/or his or her own physician notified promptly of **admission** to the hospital
- To **request or refuse treatment**. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate
- To be included in **experimental research** only when he or she gives informed, written consent to such participation. The patient may refuse to participate in experimental research, including the investigations of new drugs and medical devices
- To formulate **advance directives** and have hospital staff and practitioners who provide care in the hospital comply with these directives
- To **leave** the healthcare facility against one's physician's advice to the extent permitted by law

Access to Services

- To receive, as soon as possible, the free services of a **translator and/or interpreter, telecommunications devices**, and any other necessary services or devices to facilitate communication between the patient and the hospitals' health care personnel (*e.g.*, qualified interpreters, written information in other languages, large print, accessible electronic formats)
- To bring a service animal into the facility, except where service animals are specifically prohibited pursuant to facility policy (*e.g.*, operating rooms, patient units where a patient is immunosuppressed or in isolation)
- To **pastoral counseling** and to take part in **religious and/or social activities** while in the hospital, unless one's doctor thinks these activities are not medically advised
- To **safe, secure and sanitary accommodation** and a nourishing, well balanced and varied diet
- To access people outside the facility by means of verbal and written **communication**
- To have **accessibility** to facility buildings and grounds. We recognize the Americans with Disabilities Act, a wide-ranging piece of legislation intended to make American society more accessible to people with disabilities. The policy is available upon request
- To a prompt and reasonable **response to questions and requests** for service
- To request a discharge planning evaluation

Access to Medical Records

- To have his/her **medical records**, including all computerized medical information, kept confidential and to access information within a reasonable time frame. The patient may decide who may receive copies of the records except as required by law
- Upon leaving the healthcare facility, patients have the right to obtain **copies** of their medical records

Ethical Decisions

- To participate in **ethical decisions** that may arise in the course of care including issues of conflict resolution, withholding resuscitative services, foregoing or withdrawal of life sustaining treatment, and participation in investigational studies or clinical trials
- If the healthcare facility or its team decides that the patient's refusal of treatment prevents him/her from receiving appropriate care according to ethical and professional standards, the **relationship with the patient** may be terminated

Protective Services

- To access **protective and advocacy services**
- To be **free from restraints** of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff
- The patient who receives treatment for **mental illness or developmental disability**, in addition to the rights listed herein, has the rights provided by any applicable state law
- To all **legal and civil rights** as a citizen unless otherwise prescribed by law
- To have upon request an impartial review of **hazardous treatments** or irreversible surgical treatments prior to implementation except in emergency procedures necessary to preserve one's life
- To an impartial review of alleged **violations of patient rights**
- To expect **emergency procedures** to be carried out without unnecessary delay
- To give **consent** to a procedure or treatment and to access the information necessary to provide such consent
- To not be required to perform **work for the facility** unless the work is part of the patient's treatment and is done by choice of the patient
- To file a complaint with the Department of Health or other quality improvement, accreditation or other certifying bodies if he /she has a concern about **patient abuse**, neglect, about misappropriation of a patient's property in the facility or other unresolved complaint, patient safety or quality concern

Sign:_____ **Date:**_____

Payment and Administration

- To examine and receive an explanation of the patient's **healthcare facility's bill** regardless of source of payment, and may receive upon request, information relating to the availability of known financial resources
- A patient who is eligible for **Medicare** has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate
- To receive, upon request, prior to treatment, a reasonable **estimate of charges** for medical care
- To be informed in writing about the **facility policies and procedures** for initiation, review and resolution of patient complaints, including the address and telephone number of where complaints may be filed

Additional Patient Rights

- Except in emergencies, the patient may be **transferred to another facility** only with a full explanation of the reason for transfer, provisions for continuing care and acceptance by the receiving institution
- To initiate their own contact with the **media**
- To get the **opinion of another physician**, including specialists, at the request and expense of the patient
- To wear appropriate personal clothing and **religious or other symbolic items**, as long as they do not interfere with diagnostic procedures or treatment
- To request a **transfer to another room** if another patient or a visitor in the room is unreasonably disturbing him/her
- To request pet visitation except where animals are specifically prohibited pursuant to the facility's policies (e.g., operating rooms, patient units where a patient is immunosuppressed or in isolation)
- This facility does not provide or permit self-administered Medical Aid-In-Dying Medications on its premises

Patient Responsibilities

The care a patient receives depends partially on the patient him/herself. Therefore, in addition to the above rights, a patient has certain responsibilities. These should be presented to the patient in the spirit of mutual trust and respect.

- To provide accurate and complete information concerning his/her health status, medical history, hospitalizations, medications and other matters related to his/her health
- To report perceived risks in his/her care and unexpected changes in his/her condition to the responsible practitioner
- To report comprehension of a contemplated course of action and what is expected of the patient, and to ask questions when there is a lack of understanding
- To follow the plan of care established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders
- To keep appointments or notifying the facility or physician when he/she is unable to do so
- To be responsible for his/her actions should he/she refuse treatment or not follow his/her physician's orders
- To assure that the financial obligations of his/her healthcare care are fulfilled as promptly as possible
- To follow facility policies, procedures, rules and regulations
- To be considerate of the rights of other patients and facility personnel
- To be respectful of his/her personal property and that of other persons in the facility
- To help staff to assess pain, request relief promptly, discuss relief options and expectations with caregivers, work with caregivers to develop a pain management plan, tell staff when pain is not relieved, and communicate worries regarding pain medication
- To inform the facility of a violation of patient rights or any safety concerns, including perceived risk in his/her care and unexpected changes in their condition

Health ONE Consultants in Obstetrics and Gynecology
Physician Care℠

Visitation Rights

We recognize the importance of family, spouses, partners, friends and other visitors in the care process of patients. We adopt and affirm as policy the following visitation rights of patients/clients who receive services from our facility:

- To be informed of their visitation rights, including any clinical restriction or limitation of their visitation rights
- To designate visitors, including but not limited to a spouse, a domestic partner (including same sex), family members, and friends. These visitors will not be restricted or otherwise denied visitation privileges on the basis of age, race, color, national origin, religion, gender, gender identity, gender expression, sexual orientation or disability. All visitors will enjoy full and equal visitation privileges consistent with any clinically necessary or other reasonable restriction or limitation that facilities may need to place on such rights
- To receive visits from one's attorney, physician or clergyperson at any reasonable time
- To speak privately with anyone he/she wishes (subject to hospital visiting regulations) unless a doctor does not think it is medically advised
- To refuse visitors
- Media representatives and photographers must contact the hospital spokesperson for access to the hospital

To Report A Patient Rights Concern, Please Contact:

Consultants in Obstetrics and Gyneconolgy's Patient Rights Representative:
(303) 316-2400

The Joint Commission:

- At www.jointcommission.org, using the Report a Patient Safety Event (https://www.jointcommission.org/report_a_complaint.aspx) link in the "Action Center" on the home page of the website
- **By fax at** 630-792-5636
- **By mail to** Office of Quality and Patient Safety, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181

Quality Improvement Organization (QIO):
KEPRO
1-844-430-9504

Colorado Department of Health: 303-692-2827 or
cdphe.hfdintake@state.co.us

Department of Regulatory Agencies: 303-894-7855

HCA Ethics Line: 1-800-455-1996

If you need access to services or to report a concern regarding discrimination in access to services, contact:
Patricia Sherman ECC
2055 N High Street, Suite 140, Denver CO 80205
303-322-2240
303-322-9260
patricia.sherman@healthONEcares.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Patricia Sherman, Practice Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

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.

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.

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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Physician Care™
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Fax: 303-322-9260