Associates in Women's Health, P.C.

2801 YOUNGFIELD STREET, SUITE 200
GOLDEN, CO 80401
P: 303-940-1867 F: 303-940-1894

Please Circle Your Doctor: **ELLIS GANTER PYTHON SCHOEN WESSELL, WHNP**

PATIENT INFORMATION

Account #	Social Security #:
Name:	DOB:
Address:	
City: State:	Zip:
Race:	Ethnicity: (**Please circle**) Hispanic/Latino NOT Hispanic/Latino
Marital Status:	Spouse's Name:

Please circle your preferred telephone number .

Home Phone:
Work Phone:
Cell Phone:

IF WE MAY LEAVE RESULTS ON YOUR PREFERRED NUMBER'S VOICEMAIL, INITIAL HERE: _____

PHARMACY PHONE #:
Patient Employer/Occupation/Phone #:

Responsible Party (Guarantor) Info

Name:
Billing Address:
City: State: Zip:
Phone:

Insurance Information

Primary Insurance Carrier:	
Insurance Claims Address:	
Insurance Claims Address Cont:	
Subscriber**:**	Employer:
Subscriber DOB:	Employer Phone #:
Subscriber Sex:	
Subsciber SSN:	
Relationship to Subscriber:	
ID #:	
Group # (if applicable):	

Secondary Insurance Carrier:	
Insurance Claims Address:	
Insurance Claims Address Cont:	
Subscriber**:**	Employer:
Subscriber DOB:	Employer Phone #:
Subscriber Sex:	
Subsciber SSN:	
Relationship to Subscriber:	
ID #:	
Group # (if applicable):	

1) CONSENT TO TREATMENT

I consent to treatment by Associates in Women's Health, PC, provided by and under the care of the physician, her associates, partners, assistants, other staff and/or contracted providers. I consent to outpatient care which encompasses diagnostic examination and procedures including, but not limited to laboratory, medication, drug testing, removal and disposal of tissue, nursing or medical/surgical treatment that my physician, associates, partners, assistants may deem necessary or advisable, under the general and special instructions of the same.

2) NON-DISCRIMINATION POLICY

Associates in Women's Health, PC, will admit and treat patients regardless of race, color, national origin, religion, sex, sexual orientation, marital status, age or disability.

3) ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign my right to and authorize Associates in Women's Health, PC to bill and receive payments directly from my insurance carrier for any benefits or series of benefits covered and payable by my insurance carrier, as well as proceeds of claims resulting from the liability of third party(ies) or organizations. I further understand that prior to receiving services I may choose to pay for services directly. If I do not want my health information for that service to be provided to my insurance carrier or other third party payer.

4) NO SHOW POLICY

Please be courteous of your appointment time and allow <u>24 hour notice</u> to cancel/reschedule your appointment. Failure to do so will result in a no show fee of $50. For one hour procedures, the no show fee is $100 without a <u>72 hour notice</u>,

5) FINANCIAL AGREEMENT

I the undersigned, individually obligate myself to the payment of my Associates in Women's Health, PC account incurred by the patient's service(s). I understand that I will be responsible for charges not covered by my health insurance carrier(s). I will be expected to pay my medical bill in full when I am discharged or at the time of provision of medical services, diagnostic services and/or procedures, unless I have made other arrangements with Associates in Women's Health, PC's financial department. Should these bills not be paid, I understand that my account and any of my healthcare information necessary for collection of the bill, will be referred to an attorney or collection agency. I will be responsible for paying all attorney's fees, court costs, and other legal fees and costs incurred in collecting my medical payment, together with late fees and interest at the maximum rate allowable by law.

DISCLOSURE:

I have read and understand these documents and accept and agree to follow the conditions contained therin. I also understand that certain health information may be released to state and/or other federal agencies for reporting purposes unless otherwise stated below.

X_____ _____

Signature: Patient, Guardian, or Legal Representative* Print: Patient, Guardian, or Legal Representative

_____/_____/_____ **Date**

Associates in Women's Health, P.C.
2801 Youngfield St., Suite 200 □ Golden, CO 80401

Genetic/Family History Questionnaire

Will you be 35 years old or older at your due date?	Y N
Are you or your partner of:	
Jewish background?	Y N
Black/African background?	Y N
Mediterranean background (Italian/Greek)?	Y N
Asian background?	Y N
French/Canadian background?	Y N
Have you taken any medications (prescription or over the counter during your pregnancy?	Y N
Do you or your partner have epilepsy?	Y N
Have you used drugs (cocaine, marijuana, speed, etc) during your pregnancy?	Y N
During your pregnancy, have you taken Accutane, epilepsy medication, blood thinners, or lithium?	Y N
Are you diabetic?	Y N
Have you had radiation therapy or chemotherapy since your last menstrual period?	Y N
Are you and your partner related in any way (other than by marriage)?	Y N

Have you or your partner, or anyone in either family ever had:

	Me	My Partner	Family
A child with Down's syndrome or other chromosomal problem?	Y N	Y N	Y N
A child with mental retardation or significant learning disabilities?	Y N	Y N	Y N
Open spine (spina bifida), skull defect, or anencephaly?	Y N	Y N	Y N
Heart defect?	Y N	Y N	Y N
Muscle or neuromuscular disease (muscular dystrophy)?	Y N	Y N	Y N
Three or more miscarriages?	Y N	Y N	Y N
A stillborn baby?	Y N	Y N	Y N
A baby that died shortly after birth or in the first year?	Y N	Y N	Y N
Cystic fibrosis?	Y N	Y N	Y N
Hemophilia, sickle cell, thalssemia or other blood disorders?	Y N	Y N	Y N
Any birth defect or genetic disease not listed above?	Y N	Y N	Y N

Print Your Name _____

Date_____

Associates in WOMEN'S HEALTH

Date: _____
Patient #: _____

NAME: _____ DOB: _____

Who is your primary care physician? _____

When was the 1st day of your last menstrual period? _____

Are you currently pregnant? **YES** **NO** Total number of pregnancies? _____

Total number of births? _____ Have you ever had a miscarriage? **YES** **NO**

Have you ever had an abortion? **YES** **NO**

What are you currently using for contraception? _____
Are you experiencing any problems with it? If yes, explain: _____

How old were you when you started your period? _____

How often are your periods?
_____ less than 21 days _____ every 22-33 days _____ greater than 34 days

How long does your period last? _____

Are you periods painful? **YES** **NO** If yes, explain: _____
Do you take anything for the pain? _____
Do you experience any bleeding between cycles? **YES** **NO** If yes, explain: _____

Are you having any problems with sex? **YES** **NO**
_____ Pain with intercourse _____ Difficulty with lubrication _____ Decreased sex drive

Have you ever had any of the following STD's?
_____ Chlamydia _____Herpes (genital) _____HPV (warts) _____ Trichomonas
_____ Gonorrhea _____ HIV _____ Syphilis

Do you have, or have you ever had any of the following medical problems:
_____ Anxiety
_____ Asthma
_____ Blood clots
_____ Cancer - Type: _____
_____ Dense breast tissue
_____ Depression
_____ Diabetes ___ insulin ___ non-insulin
_____ Frequent urinary tract infections
_____ Heart disease
_____ High blood pressure
_____ High cholesterol
_____ Liver disease (Hepatitis)
_____ Migraines
_____ Thyroid problems
_____ Seizure disorder

Other_____
_____

Past surgical history: (**Please include date of surgery**)
_____
_____

See other side>>>>>>

Medications you are currently taking: (**Please include the dosage**)

_____

_____

Do you have any allergies to medications? If yes, please list:

_____

_____

Do you have a Latex allergy: **YES NO**

Do you have a family history of any of the following? (**Please include relation, age when diagnosed & if on mother's or father's side**)

Ashkenazi Jewish Heritage _____ Heart Disease _____

Breast Cancer _____ High Blood Pressure _____

Diabetes _____ Ovarian Cancer _____

Endometrial Cancer _____ Pancreatic Cancer _____

Colon Cancer _____ Skin Cancer _____

Colorectal Polyps _____ Other _____

Genetic Mutations _____ _____

Race: _____

Do you consider yourself to be: **STRAIGHT GAY/LESBIAN BISEXUAL**

What do you do for a living? _____

Marital Status: **SINGLE MARRIED SEPARATED DIVORCED WIDOWED**

Sexually active: **YES NO**
If yes, how long have you been with current partner? _____

Tobacco use: **CURRENT FORMER NEVER**
If current, how many cigarettes a day? _____ If former, when did you quit? _____

Alcohol use: **NONE RARLEY OCCASIONAL HEAVY**
How many drinks per day: _____ or per week: _____

Drug use: **NONE MARIJUANA COCAINE HEROIN IV DRUGS**

Caffeine use: **YES NO**
If yes, how may cups a day? _____

Have you ever had your Cholesterol checked? **YES NO** When? _____

When was your last Pap smear: _____
Have you ever had an abnormal pap smear? **YES NO** If yes, when? _____

Have you ever had a Mammogram? **YES NO** When? _____ **NORMAL ABNORMAL**

Have you had the chicken pox? **YES NO** If yes, when? _____

Have you received/completed the Gardasil (HPV) vaccinations? **YES NO** If yes when? _____

Pharmacy Name: _____ Address: _____
Pharmacy Number: _____

Health Care Consent Policy

Due to the ever-changing nature of health insurers and insurance plans, I understand that it is my responsibility to contact my insurance carrier to confirm that Associates in Women's Health is in network with my plan. If Associates in Women's Health is NOT in network, I understand and agree that I am responsible for the entire balance for my care.

Patient Signature: _____

Patient name (print): _____

Date: _____

Insurance:_____

Staff initials:_____

Associates in Women's Health

Consent to Leave Phone/Email/Mail Messages

At times, we may need to contact you about test results, appointments, referrals or billing/insurance information. By filling out the information below, we will be better able to serve you. In an effort to protect your privacy and follow federal guidelines, we have developed the following policy on leaving medical care messages. Unless we have written permission to do so:

- We will NOT leave messages with anyone except the patient or legal guardian
- We will NOT leave detailed messages on a voicemail or answering machines
- We will NOT send emails/mail messages

Please read below and carefully consider who, if anyone, you want to have access to your medical/account information.

I, _____ DOB:_____ give my permission for Associates in Women's Health to leave phone message and or email/mail messages regarding my medical care/account information. I fully understand that this consent will remain valid until revoked in writing by me.

How would you prefer to receive normal test results? (Please choose **ONE** option)

☐ Email (please print clearly): Email Address:_____

☐ Phone Phone Number: _____

☐ Mail Mailing Address:_____

May we leave a phone message to inform you that test results are available, give appointment reminder or with billing questions and to contact our office for more information? Please indicate the appropriate phone number below.

Home Phone: _____ ☐ Yes ☐ No

Work Phone: _____ ☐ Yes ☐ No

Cell Phone: _____ ☐ Yes ☐ No

Who else may we share your test results/medical information with on your behalf?

Spouse/Partner: ☐ Yes ☐ No If yes, name: _____

Son/Daughter: ☐ Yes ☐ No If yes, name: _____

Other: ☐ Yes ☐ No If yes, name: _____

Signature: _____ Date: _____

HIPAA CONSENT FORM

CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use/disclosure of my private health information (PHI) by Associates in Women's Health for the purposes of diagnosing, providing care and treatment to me, obtaining payment for my health care bills or conducting health care operations of Associates in Women's Health. I understand that diagnosis or treatment of me by Associates in Women's Health may be conditional upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or healthcare operations of this practice. Associates in Women's Health, is not required to agree to the restrictions that I may request. However, if Associates in Women's Health agrees to a restriction that I request, the restriction is binding on Associates in Women's Health.

I have the right to revoke this consent, in writing, at any time, except to the extent that Associates in Women's Health has taken action in reliance on this consent.

My PHI means health information, including demographics, collected from me and created or received by my physician, another health provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or other is a reasonable basis to believe the information may identify me.

I understand I have a right to review Associates in Women's Health's Notice of Privacy Practices prior to signing this document. The Associates in Women's Health's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of Associates in Women's Health. The Notice of Privacy Practices for Associates in Women's Health is also provided upon request and in the waiting room. This Notice of Privacy practice's also describes my rights and Associates in Women's Health's duties with respect to my PHI.

Associates in Women's Health reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of the privacy practice by calling the office and requesting a revised copy be sent to me in the mail or by asking for one at the time of my next appointment.

Associates in Women's Health endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the <CORHIO> HIE, or cancel an opt-out choice, at any time

_____

Signature of Patient or Personal Representative

Printed Name of Patient or Personal Representative

Description of Personal Representative's Authority

Date

Your Health Maintenance Visit and Preventive Health Benefits

Thank you for scheduling your health maintenance examination. At Associates in Women's Health, our physicians are serious about proactively keeping you healthy, and preventive medicine is the key to doing just that.

Know your Preventive Benefits

Depending on your health insurance plan, you may receive certain preventive benefits for a reduced copayment or no copayment. This is a quick reference designed to help you understand which services maybe covered under your prevention benefits and which services may not. Please be aware that if you receive care beyond what your preventive visit benefit covers, you may incur additional charges for the care provided.

*Services covered during your preventive visit**

- Age-focus exam
- Advice for disease prevention and healthy living
- Discussions about previously identified risk factors (i.e., smoking)
- Management of previously diagnosed chronic problems that are relatively stable
- Management of minor new problems that require no new lab testing, procedures, follow-up or prolonged treatment plans

Services that may NOT be covered during your preventive visit & are subject to additional charges*

- New problems that require lab tests, ultrasounds, or other evaluation
- New problems that require prescription medication
- Certain Lab tests to screen for diseases for which you may be at risk due to age
- Age-based immunizations
- Chronic problems that are significantly uncontrolled and require evaluation, management strategies, and possibly changes in medications

**Please note that this handout can not describe or define your particular preventive benefits. Please contact your insurance company for specific benefit information. Your insurance card should have a phone number or email address for you to contact them.*

Acknowledged By: _____ Date: _____