COMMUNITY HEALTH SERVICES INC

Today's Date: ___/___/___

FAMILY PLANNING REGISTRATION FORM
Please complete front and back

PATIENT INFORMATION

Last Name	First	Middle Initial

Mailing Address	City	State	Zip Code

Can we send confidential letters to the address above? ❑ Yes ❑ No	**County of Residence** ❑ Pitkin ❑ Eagle ❑ Garfield ❑ Mesa ❑ Other

Physical Address ❑ Same as Mailing Address	City	State	Zip Code

What is your gender identity:	Do you think of yourself as:	What is your preferred pronoun:
❑ Male ❑Female ❑ Transgender Female/TransWoman/MTF ❑ Transgender Male/TransMan/FTM ❑ Other:	❑ Bisexual ❑ Lesbian ❑ Gay ❑Pansexual/Polysexual ❑ Straight/Heterosexual ❑ Other:	❑ He/His ❑ She/Hers ❑ Ze/Zhr ❑ They/Theirs ❑ Other: _____

Sex Assigned at Birth ❑ M ❑F ❑Intersex	SSN	Age	Birth Date / /

If minor, Parent/ Guardian's Name	Who is your regular doctor?

Phone Number ( )	❑ Home ❑ Work ❑ Cell	Alternate Phone Number ( )	❑ Home ❑ Work ❑ Cell

CONFIDENTIAL number we can call with results? ❑Same as above ( )	**Can we text you appointment reminders?** ❑Yes ❑No

Email address	

Race: ❑ White (Hispanic) ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander ❑ American Indian/Alaskan Native

Ethnicity ❑ Hispanic/Latino ❑ Non-Hispanic

Preferred Language ❑ English ❑ Spanish ❑ Other _____

Household size_____
(include persons related by blood, marriage/partnership, or legal adoption living in the same household supported by all sources of income)

Monthly income for previous month_____
Include all sources (child support, TANF, alimony, work related income, gifts, loans)

INSURANCE

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

Is patient covered by insurance? ❑ Yes ❑ No

Can we bill the patient's insurance? ❑ Yes ❑ No

I hereby certify that all the above information is true and correct

Patient Signature_____ **Date** _____

IN CASE OF EMERGENCY

Please tell us who to contact in case of emergency (parent or guardian if under 18): An emergency would be severe bleeding, unconsciousness, accident or a condition requiring ambulance transport or hospitalization. Family planning services DO NOT require parental permission; however, in an emergency situation, if you are under 18 years of age, we will notify a parent or guardian.

Name	Relationship to Patient	Phone Number ( )

Does this person know you are receiving services here? ❑ Yes ❑ No

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Community Health Services appreciates the confidence you have shown in choosing us to provide for your health care needs. The services you have elected to receive here imply a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. You are ultimately responsible for the payment of your bill.

PATIENTS WITH MEDICAL INSURANCE BENEFITS

As a courtesy to patients and their families, Community Health Services submits claims to:

Aetna/Cofinity Rocky Mountain Health Plans United Health care Anthem Blue Cross/ Blue Shield Cigna Medicaid Medicare (Part B) – We only submit claims for the Influenza and Pneumonia vaccines.

It is your responsibility to know coverage and benefits. You are responsible for payment of any deductibles and co-payments as determined by the insurance carrier. You are also responsible for any amounts not covered by the insurer.

If you are insured by a plan that we do not participate in, payment in full is due at the time of service. Your services could be considered out of network and paid at a lower rate. You will be given a receipt which you can file with your insurance company.

PATIENTS WITHOUT MEDICAL INSURANCE

If you do not have insurance, you may be eligible for one of the discounted programs. Payment is expected at the time of service.

MINOR PATIENTS

The parent/guardian accompanying a minor is responsible for payment of the minor's account balance.

*****IMPORTANT***IF YOU ARE COVERED UNDER A PARENTS OR SPOUSES INSURANCE PLAN:**

Please be advised, a copy of services that were provided today will be sent to the policy holder. This is called an EOB (explanation of benefits) and is required by law for an insurance company to provide. **If you wish to keep your services private and not billed to your insurance please let us know.**

Community Health Services does not and shall not discriminate in any of its programs on the basis of race, color, national origin, gender, sexual orientation, religion, age, citizenship status, veteran status, disability, gender variance or other legally protected status.

Discrimination has no place at Community Health Services and is contrary to organizations' core values of inclusivity, respect and compassion. We are here to serve the entire community and will always do so.

I have read and understand my obligations to Community Health Services and I acknowledge that I am fully responsible for payment of services. I authorize my insurer to pay any benefits directly to Community Health Services. I understand that any amount remaining after such payment has been made by my insurance carrier becomes my responsibility.

_____ _____

PATIENT / PARENT OR GUARDIAN SIGNATURE DATE

Your Family History

☐ Please check here if you don't know your family history.

Yes	No	**Have your grandparents, parents, or brothers/sisters had any of the following? If yes, please list who and at what age.**
☐	☐	Blood clots in arms/legs/chest_____
☐	☐	Bleeding problems _____
☐	☐	High blood pressure_____
☐	☐	High cholesterol/triglycerides_____
☐	☐	Breast/ovarian/uterine/colon cancer_____
☐	☐	Heart attack_____
☐	☐	Stroke_____
☐	☐	Diabetes_____
☐	☐	Birth defects_____
☐	☐	Alcohol/drug abuse_____

Your Medical History

Yes	No	**Do you have now or have you had any of the following?**
☐	☐	Are you taking any prescription or over the counter medicines now? Please list: _____
☐	☐	Have you been to the ER or hospitalized in the last year?
☐	☐	Asthma
☐	☐	Heart disease, high blood pressure
☐	☐	Blood clots in arms/legs/chest
☐	☐	Heart attack or stroke
☐	☐	High cholesterol/triglycerides
☐	☐	Migraines or frequent headaches
☐	☐	Visual changes or numbness
☐	☐	Lupus (SLE)
☐	☐	Cancer: What type? _____ When? _____
☐	☐	Blood problems (Sickle cell anemia, hemophilia, low iron)
☐	☐	Have you or your partner(s) ever had a blood transfusion, tissue/organ transplant or artificial insemination?
☐	☐	Inflammatory bowel disease (IBD)
☐	☐	Gall bladder disease
☐	☐	Surgery - List type and date:_____
☐	☐	Thyroid problems
☐	☐	Breast disease
☐	☐	Mammogram - date _____
☐	☐	Kidney or bladder problems
☐	☐	Liver disease (hepatitis, mono, jaundice, cirrhosis)
☐	☐	Diabetes
☐	☐	Epilepsy or convulsions
☐	☐	Depression or emotional problems

Patient Identification:

Today's date: _____

Birth date: _____ Age: _____

List any medicines, foods, latex, etc. that you are allergic to and the reaction you have: _____

Your Personal History

Yes	No	
☐	☐	Do you smoke or use any form of tobacco? How much per day?_____
☐	☐	Do you drink alcohol? How many drinks a day?____ Per week?_____
☐	☐	Do you ever feel you should cut down on your drinking?
☐	☐	Have you used marijuana in the past year?
☐	☐	In the past year, have you used an illegal drug or a prescription drug for non-medical reasons?
☐	☐	Have you ever been hit, slapped, kicked, shaken or hurt by anyone?
☐	☐	Is there anyone who makes you feel unsafe now?
☐	☐	Have you ever been forced to have sex?

Your Nutritional History

Yes	No	
☐	☐	Are there changes you would like to make to your diet? If yes, describe:_____
☐	☐	Do you exercise regularly? Describe: _____

List any supplements, herbs or weight loss preparations you use:

_____

Immunizations (list date(s))

Yes	No	
☐	☐	Measles, mumps, rubella (MMR) vaccine _____
☐	☐	Tetanus, diphtheria, pertussis (Td/Tdap)vaccine _____
☐	☐	Hepatitis A vaccine_____
☐	☐	Hepatitis B vaccine _____
☐	☐	Varicella (chicken pox) vaccine_____
☐	☐	HPV (human papilloma virus) vaccine_____
☐	☐	Flu vaccine_____

Your Sexual/ Reproductive Health

Have you ever had any of the following sexually transmitted infections:

Yes	No	
☐	☐	Chlamydia
☐	☐	Gonorrhea
☐	☐	Genital warts/Human Papillomavirus (HPV)
☐	☐	Syphilis
☐	☐	Herpes
☐	☐	Trichomoniasis
☐	☐	Non-gonococcal urethritis (NGU)
☐	☐	Have you or your sexual partner(s) ever used needles for drugs (to shoot drugs)?
☐	☐	Have you or your sexual partner(s) ever exchanged sex for drugs or money?
☐	☐	Do you use condoms? Never____ Sometimes___ Always_____
☐	☐	Have you had HIV testing? When? _____
☐	☐	Was the HIV test positive (HIV infection found)?
☐	☐	Have you had a new partner in the past 2 months?
☐	☐	Does your sex partner have other partners?

1. How many sexual partners have you had in the past 2 months? __
2. How many sexual partners have you had in the past year? __
3. Are your sex partners: male ____ female ____ both____ transman_____ transwoman____ intersex___ other____
4. Do you have: Vaginal sex___? Oral sex ____receive ___give ____both ____? Anal sex____ top (insertive) ___bottom (receptive) ____both_____?
5. When was the last time you had sex? _____
6. Have any of your male partners had sex with other men? Yes ____ No ____ N/A ____
7. Are any of your sex partners living with HIV? Yes ____ No ____

(Male/Assigned male at birth/MTF)

Your Urological History

Yes	No	
☐	☐	Do you have abnormal discharge from the penis now? Describe: _____
☐	☐	Do you have now or in the past a lesion, sore, or lump on your penis? Describe:_____ When?_____
☐	☐	Do you have now or had in the past a lesion, sore, or lump on your scrotum or testicles? Describe: _____ When?_____
☐	☐	Have you ever had pain during sex? When?_____
☐	☐	Have you had gender affirming surgery? If so, describe: _____

Your Reproductive History

Yes	No	
☐	☐	How many children do you have? _____
☐	☐	Do you want children in the future?
☐	☐	Are you using birth control? Please check the birth control method(s) you use: □ Condoms □ Vasectomy □ Rely on partner's method. What method does your partner use?_____

(Female / Assigned female at birth/ FTM)

Do you want to become pregnant in the next year? Yes __ No __

Menstrual History

Date of the first day of your last menstrual period: _____

Yes	No	
☐	☐	Was your last menstrual period normal? If not, explain: _____
☐	☐	Do you have a period every month? Is the flow: ___light ___ medium ___ heavy
☐	☐	Do you bleed between periods?
☐	☐	Do you have cramps with your periods?
☐	☐	Do you take medication for cramps? ☐ Over the counter ☐ Prescription medication

How old were you when you had your first period? __

Your Pregnancy History

How many times have you been pregnant? _____
List the dates that you gave birth: _____
How many living children do you have? _____
List the dates of any miscarriages or abortions: _____
List the dates of any tubal pregnancies: _____
Are you breast-feeding now? Yes __ No __

Yes	No	
☐	☐	Have you had a baby that weighed less than 5 1/2 pounds?_____
☐	☐	Have you had a baby that weighed more than 9 pounds?_____
☐	☐	During any pregnancy did you have high blood pressure, diabetes, or a baby with birth defects?_____

Your Gynecological History

When was your last Pap test done? _____

Yes	No	**Have you had any of the following?**
☐	☐	Abnormal Pap test If yes, when? _____
☐	☐	Colposcopy or treatment of your cervix (When?)_____
☐	☐	Ovary problems
☐	☐	Uterus problems or uterine fibroids
☐	☐	Pelvic Inflammatory Disease (PID)
☐	☐	Pain or other problems with sex
☐	☐	Vaginal infections (yeast or bacterial vaginosis)
☐	☐	Have you had gender affirming surgery? If so, describe: _____

Your Birth Control History

Yes	No	
☐	☐	Are you using a method of birth control now? If yes, what method?_____
☐	☐	Have you used any birth control methods that you have had a problem with? What method/s?_____
☐	☐	In the last 5 days or since your last period, have you had sex without birth control? (condoms are birth control)

Client Signature _____ Date_____ Provider Signature _____ Date_____

Family Planning Program Consent

COMMUNITY HEALTH SERVICES 0405 Castle Creek Rd. Ste 201, Aspen, CO 81611

Name:_____ Birth date: _____

I,_____, give my consent to the clinical staff of the above named clinic to examine, treat and counsel me. I understand and agree with the following:

Services

- Family planning services may include: review of my health history, routine family planning visits to start a birth control method, sexually transmitted infection and HIV screening and risk reduction counseling, pregnancy testing and counseling, preconception screening and counseling, and referral for care not provided at this clinic.
- I will be provided information about the test(s), procedure(s), treatment(s) and birth control methods(s) prior to any of these services being provided. This information will include the benefits, risks, possible problems or complications and other choices. I will ask questions about anything I do not understand.
- It is my choice whether or not to receive services and I can change my mind about receiving services at this clinic at any time.
- No guarantee is given to me as to the results of any services I receive.
- I agree to a physical exam, including a breast exam and pelvic or genital exam, if one is recommended.
- My provider might recommend lab tests, including a Pap test, if needed.
- I may be referred to anther health care provider for further testing or treatment if necessary.
- Receiving family planning services is not a requirement to receiving any other services offered at the clinic.

Payment

- There are certain hazards and risks connected with all forms of medical care and treatment that may result in additional costs to me (the client).
- There is no guarantee of payment by insurance or by an aid program for any costs that the family planning program does not cover and for which I am responsible.
- I may be billed for non-Title X services including, but not limited to, colposcopy or treating complications resulting from Title X-covered procedures or side effects from medications.
- Some lab tests may not be paid for by the family planning program. My provider will discuss these with me.
- If I need a referral to another health care provider, I will assume responsibility for getting and paying for this care.

Privacy

- All information about me is kept in strictest confidence and will not be released to anyone without my permission, except as required by law. This could include:
    - Positive test results of some sexually transmitted diseases
    - Sexual or physical abuse of minors
    - Physical signs of domestic violence or intimate partner violence
- I understand that this health care clinic uses a statewide database that makes my health information available to the Colorado state health department for program reporting purposes.

I have read the above information. It has been explained to me and I understand it. My questions have been answered by a person from the clinic.

_____ _____

Signature of client Date

The client received the above information and I believe she or he understands it.

_____ _____

Signature of staff Date

Interpreter identification information _____

COMMUNITY HEALTH SERVICES INC

YOU SHOULD KNOW…
YOUR INFORMATION IS SAFE AND SECURE!

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

The federal government's Health Insurance Portability and Accountability Act (HIPAA) ensures that Designated Healthcare Services (DHS) comply with guidelines regarding the release of protected health information (PHI). This handout summarizes the guidelines.

At the time you receive services, Community Health Services, Inc. obtains permission to use and disclose your health information for purposes of providing treatment to you, obtaining payment for healthcare services provided to you, and for the agencies internal operations.

We are committed to every reasonable measure to ensure your health information is protected. Use and disclosure of your protected health information will be made only with your written authorization.

We will never use your PHI without your permission or marketing purposes, nor will we sell, rent or barter your PHI. It will not be disclosed to an employer for use in employment determinations, or for the purposes of fundraising.

No information will be given to any person without your specific release of information. Such release may be revoked by you in writing at any time. However, if required by law we may release information regarding your PHI without your authorization.

Contacting you: It may be necessary to contact you at your place of residence for follow-up care or to confirm appointments. **If you object to this, please let us know immediately.**

Rights: HIPAA also give you certain rights regarding your protected health information. These rights include the right to request restrictions on certain uses and disclosures, the right to inspect and copy your record, the right to request amendments to your health information, and the right to receive an accounting of disclosures of your protected health information.

This document is only a summary of Community Health Services' privacy policy and your privacy rights. It does not list all exceptions or potential uses of your protected health information. If you would like a complete copy of our privacy policy, or if you have question or complaint, you may contact our Privacy Officer at 970-920-5010.

Signing this document means that you have read a copy of Community Health Services, Inc. Notice of Privacy Practices.

_____

Print Client Name Date

_____

Client Signature Date

_____

Witness Signature Date