



DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

*\* Please Complete All Pages\**

**PATIENT INFORMATION**

Last Name		First		Middle Initial	
Mailing Address			City	State	Zip Code
Can we send confidential letters to the address above? <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>County of Residence</b> <input type="checkbox"/> Pitkin <input type="checkbox"/> Eagle <input type="checkbox"/> Garfield <input type="checkbox"/> Mesa <input type="checkbox"/> Other		
Physical Address <input type="checkbox"/> Same as Mailing Address			City	State	Zip Code
What is your gender identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female/TransWoman/MTF <input type="checkbox"/> Transgender Male/TransMan/FTM <input type="checkbox"/> Other:		Do you think of yourself as: <input type="checkbox"/> Bisexual <input type="checkbox"/> Lesbian <input type="checkbox"/> Gay <input type="checkbox"/> Pansexual/Polysexual <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Other:		What is your preferred pronoun: <input type="checkbox"/> He/His <input type="checkbox"/> She/Hers <input type="checkbox"/> Ze/Zhr <input type="checkbox"/> They/Theirs <input type="checkbox"/> Other:	
Sex Assigned at Birth <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Intersex	SSN		Age	Birth Date ____/____/____	
If minor, Parent/ Guardian's Name			Who is your regular doctor?		
Phone Number (____) _____	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		Alternate Phone Number (____) _____	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	
<b>CONFIDENTIAL</b> number we can call with results? <input type="checkbox"/> Same as above (____) _____			<b>Can we text you appointment reminders?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
Email address					

<b>Race:</b>	<input type="checkbox"/> White (Anglo or Hispanic)	<input type="checkbox"/> Asian	<input type="checkbox"/> Black
	<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Indian	
<b>Ethnicity</b>	<input type="checkbox"/> Hispanic/Latino		<input type="checkbox"/> Non-Hispanic
<b>Preferred Language</b>	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other _____

<b>Household size</b> _____ (include persons related by blood, marriage/partnership, or legal adoption living in the same household supported by all sources of income)	<b>Household monthly income for previous month</b> _____ Include all sources (child support, TANF, alimony, work related income, gifts, loans)
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**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 Client	Phone Number (     )
------	------------------------	-------------------------

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

**STATEMENT OF CLIENT FINANCIAL RESPONSIBILITY**

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

**TO OUR CLIENTS WITH MEDICAL INSURANCE COVERAGE:**

We are contracted with the insurance companies below and will submit claims directly to:

- Aetna \* Rocky Mountain Health Plans \* UnitedHealthcare \* Anthem BC \* Cigna/Great West
- Medicaid: Health First Colorado, Rocky Mountain Prime
- Medicare Part B: We submit only claims for Influenza and Pneumococcal vaccines

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

**If you are insured by a plan with which we do not participate, payment in full is due at the time of service. You will then be given a receipt to file with your insurance company.**

**CLIENTS 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 CLIENTS**

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

**\*\*\*IMPORTANT\*\*\*IF YOU ARE COVERED UNDER A PARENT’S OR SPOUSE’S INSURANCE PLAN:**

Please be advised, when services are billed to insurance, the insurance company is required to provide an Explanation of Benefits (EOB) detailing what treatment was done and how the claim was processed. This will be sent to the *insured*.

**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 organization's 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 is my responsibility.**

\_\_\_\_\_  
CLIENT / PARENT OR GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

**Your Family History**

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

**Have your grandparents, parents, or brothers/sisters had any of the following? If yes, please list who and at what age.**

- | Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Blood clots in arms/legs/chest _____      |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding problems _____                   |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure _____                 |
| <input type="checkbox"/> | <input type="checkbox"/> | High cholesterol/triglycerides _____      |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast/ovarian/uterine/colon cancer _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke _____                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes _____                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth defects _____                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol/drug abuse _____                  |

**Your Medical History**

**Do you have now or have you had any of the following?**

- | Yes                      | No                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking any prescription or over the counter medicines now?<br>Please list: _____                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been to the ER or hospitalized in the last year?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma   |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease, high blood pressure   |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood clots in arms/legs/chest   |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack or stroke   |
| <input type="checkbox"/> | <input type="checkbox"/> | High cholesterol/triglycerides   |
| <input type="checkbox"/> | <input type="checkbox"/> | Migraines or frequent headaches  |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual changes or numbness   |
| <input type="checkbox"/> | <input type="checkbox"/> | Lupus (SLE)  |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer: What type? _____ When? _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood problems (Sickle cell anemia, hemophilia, low iron)  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you <u>or your partner(s)</u> ever had a blood transfusion, tissue/organ transplant or artificial insemination? |
| <input type="checkbox"/> | <input type="checkbox"/> | Inflammatory bowel disease (IBD)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Gall bladder disease   |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgery - List type and date: _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast disease   |
| <input type="checkbox"/> | <input type="checkbox"/> | Mammogram - date _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney or bladder problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease (hepatitis, mono, jaundice, cirrhosis)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes   |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or convulsions  |
| <input type="checkbox"/> | <input type="checkbox"/> | 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                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke or use any form of tobacco?<br>How much per day? _____                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink alcohol? How many drinks a day? ____<br>Per week? _____                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you ever feel you should cut down on your drinking?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you used marijuana in the past year?   |
| <input type="checkbox"/> | <input type="checkbox"/> | In the past year, have you used an illegal drug or a prescription drug for non-medical reasons? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hit, slapped, kicked, shaken or hurt by anyone?                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there anyone who makes you feel unsafe now?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been forced to have sex?  |

**Your Nutritional History**

- | Yes                      | No                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Are there changes you would like to make to your diet? If yes, describe: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you exercise regularly? Describe: _____                                     |

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

**Immunizations (list date(s))**

- | Yes                      | No                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Measles, mumps, rubella (MMR) vaccine _____            |
| <input type="checkbox"/> | <input type="checkbox"/> | Tetanus, diphtheria, pertussis (Td/Tdap) vaccine _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A vaccine _____                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B vaccine _____                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Varicella (chicken pox) vaccine _____                  |
| <input type="checkbox"/> | <input type="checkbox"/> | HPV (human papilloma virus) vaccine _____              |
| <input type="checkbox"/> | <input type="checkbox"/> | Flu vaccine _____                                      |

**Your Sexual/ Reproductive Health**

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

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <b>Yes</b>               | <b>No</b>                |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Chlamydia  |
| <input type="checkbox"/> | <input type="checkbox"/> | Gonorrhea  |
| <input type="checkbox"/> | <input type="checkbox"/> | Genital warts/Human Papillomavirus (HPV)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Syphilis   |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes   |
| <input type="checkbox"/> | <input type="checkbox"/> | Trichomoniasis   |
| <input type="checkbox"/> | <input type="checkbox"/> | Non-gonococcal urethritis (NGU)  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you or your sexual partner(s) ever used needles for drugs (to shoot drugs)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you or your sexual partner(s) ever exchanged sex for drugs or money?        |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use condoms?<br>Never ___ Sometimes ___ Always ___                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had HIV testing? When? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Was the HIV test positive (HIV infection found)?                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a new partner in the past 2 months?                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your sex partner have other partners?                                       |
- How many sexual partners have you had in the past 2 months? \_\_\_
  - How many sexual partners have you had in the past year? \_\_\_
  - Are your sex partners: male \_\_\_ female \_\_\_ both \_\_\_  
transman \_\_\_ transwoman \_\_\_ intersex \_\_\_ other \_\_\_
  - Do you have: Vaginal sex \_\_\_?  
Oral sex \_\_\_ receive \_\_\_ give \_\_\_ both \_\_\_?  
Anal sex \_\_\_ top (insertive) \_\_\_ bottom (receptive) \_\_\_ both \_\_\_?
  - When was the last time you had sex? \_\_\_\_\_
  - Have any of your male partners had sex with other men?  
Yes \_\_\_ No \_\_\_ N/A \_\_\_
  - Are any of your sex partners living with HIV? Yes \_\_\_ No \_\_\_

**(Male/Assigned male at birth/MTF)**

**Your Urological History**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <b>Yes</b>               | <b>No</b>                |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have abnormal discharge from the penis now?<br>Describe: _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have now or in the past a lesion, sore, or lump on your penis?<br>Describe: _____ When? _____                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have now or had in the past a lesion, sore, or lump on your scrotum or testicles?<br>Describe: _____<br>When? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had pain during sex?<br>When? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had gender affirming surgery? If so, describe:<br>_____   |

**Your Reproductive History**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <b>Yes</b>               | <b>No</b>                |  |
| <input type="checkbox"/> | <input type="checkbox"/> | How many children do you have? _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you want children in the future?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you using birth control?<br>Please check the birth control method(s) you use: <input type="checkbox"/> Condoms <input type="checkbox"/> Vasectomy<br><input type="checkbox"/> 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: \_\_\_\_\_

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <b>Yes</b>               | <b>No</b>                |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Was your last menstrual period normal?<br>If not, explain: _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a period every month?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the flow: ___ light ___ medium ___ heavy   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you bleed between periods?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have cramps with your periods?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you take medication for cramps?<br><input type="checkbox"/> Over the counter<br><input type="checkbox"/> 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 \_\_\_

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <b>Yes</b>               | <b>No</b>                |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a baby that weighed less than 5 1/2 pounds? _____                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a baby that weighed more than 9 pounds? _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | 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? \_\_\_\_\_

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <b>Yes</b>               | <b>No</b>                | <b>Have you had any of the following?</b>                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Pap test<br>If yes, when? _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Colposcopy or treatment of your cervix (When?) _____             |
| <input type="checkbox"/> | <input type="checkbox"/> | Ovary problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | Uterus problems or uterine fibroids                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Pelvic Inflammatory Disease (PID)                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain or other problems with sex                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal infections (yeast or bacterial vaginosis)                |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had gender affirming surgery? If so, describe:<br>_____ |

**Your Birth Control History**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <b>Yes</b>               | <b>No</b>                |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you using a method of birth control now? If yes, what method? _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you used any birth control methods that you have had a problem with?<br>What method/s? _____                 |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 04 05 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 another 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 \_\_\_\_\_



**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.

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Print Client Name \_\_\_\_\_ Date \_\_\_\_\_

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Client Signature \_\_\_\_\_ Date \_\_\_\_\_

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Witness Signature \_\_\_\_\_ Date \_\_\_\_\_