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? ❑ 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 ____/____/____

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

Email address

CONFIDENTIAL number we can call with results? ❑ Same as above ( )

Can we text you appointment reminders? ❑ Yes ❑ No

Who is your regular doctor?

Race: ❑ White (Anglo or Hispanic) ❑ Asian ❑ Black ❑ Hawaiian ❑ Indian

Ethnicity ❑ Hispanic/Latino ❑ Non-Hispanic

Preferred Language ❑ English ❑ Spanish ❑ Other ______________________________

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

Combined Family Monthly Income ______________________________

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 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 ____________

Patient Identification

Today's date:____/____/______ Birth date:____/____/______

Client name: ______________________________ Age: __________

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

Nutritional History

Yes **No** Are there changes you would like to make to your diet? If yes, describe: ____

Yes **No** Do you exercise regularly? Describe: ____________________

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

____

Immunizations (list dates)

Yes **No** Measles, mumps, rubella (MMR) __________
Yes **No** Tetanus, diphtheria, pertussis (Tdap) __________
Yes **No** Hepatitis A __________
Yes **No** Hepatitis B __________
Yes **No** Varicella (chicken pox) __________
Yes **No** HPV (Human Papillomavirus) __________
Yes **No** Influenza (Flu) __________

Your Family History

☐ Check here is you do not know your family history.

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

Yes **No** Blood clots in arms/legs/chest _______________
Yes **No** Bleeding problems _______________
Yes **No** High blood pressure (hypertension) _______________
Yes **No** High cholesterol/triglycerides _______________
Yes **No** Breast/ovarian/uterine/colon cancer _______________
Yes **No** Heart attack _______________
Yes **No** Stroke _______________
Yes **No** Diabetes _______________
Yes **No** Birth defects _______________
Yes **No** Alcohol/drug misuse or abuse _______________

Your Medical History

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

Yes **No** Are you taking any prescription or over the counter medicines?
Please list: ____
Yes **No** Have you been to the ER or hospitalized in the last year?
Please list: ____
Yes **No** Asthma
Yes **No** Heart disease or high blood pressure (hypertension)
Yes **No** Heart attack or stroke
Yes **No** High cholesterol/triglycerides
Yes **No** Migraines or frequent headaches
Please describe: ____
Yes **No** Visual changes or numbness
Yes **No** Lupus (SLE)
Yes **No** Cancer
Please list type and year diagnosed: _________________________
Yes **No** Blood problems (Sickle cell anemia, hemophilia, low iron)
Yes **No** Have you or your partner(s) ever had a blood transfusion, tissue/organ transplant, or artificial insemination?
Yes **No** Inflammatory bowel disease (IBD)
Yes **No** Gall bladder disease
Yes **No** Surgery Please list: ________________________________
Yes **No** Breast disease
Yes **No** Mammogram Date of last mammogram: _____/___/_____

Your Medical History Continued

Yes **No** Kidney or bladder problems
Yes **No** Liver disease (hepatitis, mono, jaundice, cirrhosis)
Yes **No** Diabetes
Yes **No** Epilepsy, seizures or convulsions
Yes **No** Depression or other mental health concerns
Yes **No** Have you had gender affirming surgery?

Your Sexual and Reproductive Health

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

Yes **No** Chlamydia
Yes **No** Gonorrhea
Yes **No** Genital warts/Human Papillomavirus (HPV)
Yes **No** Syphilis
Yes **No** Herpes
Yes **No** Trichomoniasis
Yes **No** Non-gonococcal urethritis (NGU)
Yes **No** Have you or your sexual partner(s) ever used needles to shoot drugs?
Yes **No** Have you or your sexual partner(s) ever exchanged sex for drugs or money?
Yes **No** Do you use condoms (either external or internal)
If yes, how often: Never Sometimes Always
Yes **No** Have you ever been tested for HIV? When? ______
Yes **No** Have you had a positive HIV test result?
Yes **No** Have you had a new partner in the past 2 months?
How many lifetime sexual partners have you had? # _________
Yes **No** Are your sex partners: male ____ female ____ both ____ transgender ____ transsexual ____ intersex ____ non-binary ____ other ____
Yes **No** Do you have vaginal sex?
Yes **No** Do you have oral sex? Circle all that apply.
Receive/Bottom Give/Top
Yes **No** Do you have anal sex? Circle all that apply.
Insertive/Top Receptive/Bottom Both
When was the last time you have sex? _____________________
Yes **No** Have any male partners had sex with other men?
Yes **No** Are any of your sex partners living with HIV?
Yes **No** Do you have a trusted adult to talk to about things like healthy relationships, sex, and birth control?
Yes **No** Has a partner ever forced you to do something sexually that you did not want to do or refused your request to use condoms?
Yes **No** Does your partner support your decision about when or if you want to become pregnant?

Complete these questions only if you are ***male, assigned male at birth****, or (male to female)* ***MTF***

Your Urological History

Yes **No** Do you have abnormal discharge from the penis?
Yes **No** Do you have now or in the past a lesion, sore, or lump on your penis, scrotum or testicles?
Yes **No** Have you ever had pain with sex? When: ________

Your Reproductive History

How many children do you have? _____________
Yes **No** Do you think you might want to have (more) children at some point?
When do you think that might be? ______________________
How important is it to you to prevent pregnancy? ____________
Yes **No** Are you using birth control?
If so, which method are you using: _____________

Client name: ______________________________

*Complete these questions only if you are **female, assigned female at birth**, or female to male (**FTM**)*

Your Menstrual History

Please share the date of your last menstrual period (first day):
____/____/____

Yes **No** Was your last menstrual period normal?
Yes **No** Do you have a period every month?
Is the flow: light_____ medium_____ heavy_____
Yes **No** Do you bleed between periods?
Yes **No** Do you have cramps with your periods?
Yes **No** Do you take medication for cramps? What type:___________
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: ____________________________
Yes **No** Are you breastfeeding now?
Yes **No** Have you had a baby that weighed less than 5 ½ pounds?
Yes **No** Have you had a baby that weighed more than 9 pounds?
Yes **No** During any pregnancy, did you have high blood pressure, diabetes, or a baby with birth defects?

Your Gynecological History

When was your last Pap or HPV screening done? _______________
Have you had any of the following?
Yes **No** Abnormal Pap or HPV result? If yes, when? _____________
Yes **No** Colposcopy, biopsy or treatment of your cervix?
If yes, when? ________________
Yes **No** Ovary problems
Yes **No** Uterus problems or uterine fibroids?
Yes **No** Pelvic Inflammatory Disease (PID)
Yes **No** Pain or other problems with sex
Yes **No** Vaginal infections (yeast or bacterial)

Your Birth Control History

Yes **No** Do you think you might want to have (more) children at some point?
When do you think that might be? _______________________________
How important is it to you to prevent pregnancy? _________________
Yes **No** Are you using a method of birth control now?
If yes, what method? ___________________________
Yes **No** Have you used a birth control method that you had a problem with? Please describe: _______________________
____
Yes **No** In the last 5 days or since your last period, have you had sex without birth control or did your method of birth control fail (condoms are birth control)?

Over the last 2 weeks, how often have you been bothered by the following problems?

Little interest or pleasure in doing things
0 1 2 3
Feeling down, depressed or hopeless
0 1 2 3
**PHQ-2 (If screen is positive, use PHQ-9)*

Yes **No** Have you been hit, punched, or otherwise hurt by someone within the past year? If so, by whom?
____
Yes **No** Do you feel safe in your current relationship?
Yes **No** Is there a partner from a previous relationship who is making you feel unsafe now?
**PVS*

Yes **No** Have you ever been emotionally or physically abused by your partner or someone important to you?

Yes **No** Within the last year, have you ever been hit, slapped, kicked, or otherwise physically hurt by someone? If YES, who? (circle all that apply)
Partner Ex-Partner Stranger Other Multiple
Total # of times: ____________

Yes **No** Within the last year, has anyone forced you to have sexual activities? If YES, who? (circle all that apply)
Partner Ex-Partner Stranger Other Multiple
Total # of times: ____________

Yes **No** Are you afraid of your partner or anyone listed above?

Answer the following question only if you are currently pregnant:

Yes **No** Since you've been pregnant, have you been slapped, kicked, or otherwise physically hurt by someone? If YES, who? (circle all that apply)
Partner Ex-Partner Stranger Other Multiple

**AAS (Please use AAS-D as needed)*

Client name: ____________________________

Please answer these questions if you are under the age of 22.

During the past 12 months, did you:

Yes **No** Drink any alcohol (more than a few sips)?
Yes **No** Use any marijuana or hashish?
Yes **No** Use anything else to get high (i.e. illegal drugs, over the counter and prescription drugs, and things that you sniff or huff)?

If you answered **yes** to any of these questions above, please answer the following questions:

Yes **No** Have you ever ridden in a **car** driven by someone (including yourself) who has "high" or had been using alcohol or drugs?
Yes **No** Do you ever use alcohol or drugs to **relax**, feel better about yourself, or fit in?
Yes **No** Do you ever use alcohol or drugs while you are by yourself, or **alone**?
Yes **No** Do you ever **forget** things you did while using alcohol or drugs?
Yes **No** Do your **family** or **friends** ever tell you that you should cut down on your drinking or drug use?
Yes **No** Have you ever gotten into trouble while you were using alcohol or drugs?

**CRAFFT for adolescents*

Please answer these questions if you are over the age of 21.

In the past year, how often have you used the following?

Alcohol (For men, 5 or more drinks/day. For women, 4 or more drinks/day)
Never Once or Twice Monthly Weekly Daily or Almost Daily

Tobacco/Marijuana Products
Never Once or Twice Monthly Weekly Daily or Almost Daily

Prescription Drugs for Non-Medical Reasons
Never Once or Twice Monthly Weekly Daily or Almost Daily

Illegal Drugs
Never Once or Twice Monthly Weekly Daily or Almost Daily

**NIDA ASSIST for adults*

Client Signature: ____ Date: ________________________

Healthcare 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 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 _____________________________

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