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: ❑ Male ❑Female ❑ Transgender Female/TransWoman/MTF ❑ Transgender Male/TransMan/FTM ❑ Other:		Do you think of yourself as: ❑ Bisexual ❑ Lesbian ❑ Gay ❑Pansexual/Polysexual ❑ Straight/Heterosexual ❑ Other:	What is your preferred pronoun: ❑ 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 ❑ Declined to answer/Unknown

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**_______________________

Community Health Services, Inc. 0405 Castle Creek Road, #201 Aspen, CO 81611 Phone (970)920-5420 Fax (970) 920-5419

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