COMMUNITY HEALTH SERVICES INC

**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?<br>❑ Yes ❑ No | **County of Residence**<br>❑ Pitkin ❑ Eagle ❑ Garfield ❑ Mesa ❑ Other |
|---|---|

| Physical Address ❑ Same as Mailing Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

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

| Sex Assigned at Birth<br>❑ M ❑F ❑Intersex | SSN | Age | Birth Date<br>____/____/____ |
|---|---|---|---|
| | | | |

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

| Phone Number<br>( ) | ❑ Home ❑ Work ❑ Cell | Alternate Phone Number<br>( ) | ❑ Home ❑ Work ❑ Cell |
|---|---|---|---|
| | | | |

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

| Email address | |
|---|---|
| | |

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

**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 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

**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 _____

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

## EMERGENCY CONTRACEPTION PROGRESS NOTE

Patient Name _____ Date _____

Date of Birth _____

**SUBJECTIVE: (CLIENT PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY)**

1. The first day of my last normal menstrual period was _____

2. Date of my last intercourse _____ Time: _____

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**OBJECTIVE: (CLINICIAN TO COMPLETE)**

Blood Pressure: _____ Pregnancy Test: Positive Negative N/A

**ASSESSMENT**:

Based on the information above, there ARE ARE NOT contraindications to starting emergency contraception.

**PLAN:**

| | PILL BRAND NAME | INITIAL DOSE | DOSE-12 HOURS AFTER INITIAL |
|---|---|---|---|
| | Lo/Ovral | 4 white pills | 4 white pills |
| | Levlen | 4 light-orange pills | 4 light-orange pills |
| | Nordette | 4 light-orange pills | 4 light-orange pills |
| | Triphasil | 4 yellow pills | 4 yellow pills |
| | Alesse | 5 pink pills | 5 pink pills |
| | Plan B | 2 pills | No second dose needed |
| | Next Choice® | 2 pills | No second dose needed |
| | Plan B One Step™ | 1 pill | No second dose needed |
| | **ella®** | 1 pill | No second dose needed |

__ Emergency Contraception Instructions
__ Emergency contact information
__ Return to clinic in 3 - 4 weeks if no menses or if desires Family Planning Services
__ Other _____

__ FDA package insert
__ Dispensed condoms
__ Consent signed (if **<17 years old for levonorgestral products and all ages for ella and combined oral contracpetives**)

Discussed Contraceptive plan: Dispensed method: _____

**Clinician Signature** _____ **Date** _____

## EMERGENCY CONTRACEPTION (EC) CONSENT / INFORMATION

**WHAT IS IT?** Emergency contraceptive pills (EC) are hormone pills (like birth control pills) that you take right after unprotected sex to try to reduce your chance of pregnancy.

**THEY WORK BY:**

- Keeping the ovary from releasing an egg;
- Making the mucus from the cervix thick so the sperm can't get into the uterus;
- They work best if they are taken within 120 hours after having sex without birth control.

**HOW DO I TAKE IT?** 1.) For Plan B or Next Choice®, swallow both pills while you are in the clinic. For Plan B One Step™, swallow the single pill while you are in the clinic. 2.) **For ella®, swallow the single pill while you are in the clinic.** 3.) For all other options, swallow the first dose of EC as soon as you can. Swallow the second dose 12 hours after you took the first dose. 4.) Some kinds of EC can make you feel sick to your stomach. Ask your provider if she or he recommends you take an over-the-counter medicine for nausea, like Dramamine or Bonamine before the first dose of EC.

**HOW WELL DOES IT WORK?** EC does not work every single time. If you don't start your period within 3 weeks after taking EC, call the clinic. EC should just be used in an emergency. It is not good as a regular method of birth control. After you use EC, you should start using a reliable method of birth control right away.

**CAN EVERYONE TAKE EC?** You should not take EC if you already know for sure that you are pregnant. If you are pregnant but don't know it, or if the EC doesn't work and you are pregnant, it will not hurt you or the pregnancy to take EC. **You should not use ella if you suspect you are pregnant or are breastfeeding. Also, ella may reduce the effectiveness of your regular hormonal method so you should continue your hormonal method and use a reliable barrier contraceptive method after using ella. Ella should not be used more than once in the same menstrual cycle.**

**WHAT WILL I FEEL LIKE WHEN I TAKE EC?** You may not have any symptoms. Some women may have one or more of the following:

- Nausea or vomiting;
- Tender breasts;
- Headaches;
- Dizziness or tiredness;
- Irregular bleeding
- **Stomach pain**

Your next period after you take EC may be different than your periods usually are. It may be early or late, and it might be heavier or lighter.

**Call the clinic or go to the nearest emergency room if you have:**

**Very bad headaches**

**Very bad abdominal pain**

**Changes in your vision**

**Trouble breathing or chest pain**

**Very bad leg pain**

**Heavy bleeding**

You have been given _____ Take_____pill(s) now; Take _____ pill(s) in 12 hours.

If you have any questions, call the clinic at _____

Patient signature _____ Date _____

Staff signature _____ Date _____

INTERPRETER'S STATEMENT

I have translated the information and advice presented orally to the client who has chosen to use Emergency Contraception. I have also read this consent to her in a language she understands and explained the content to her. To the best of my knowledge and belief she understands this explanation and voluntarily consents to the use of Emergency Contraception.

_____ _____

Interpreter's Signature Date