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? ❑ 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 (Anglo or 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 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

Comprehensive Family Planning History - Male

Patient Identification:

Today's date: _____
Birth date: _____ Age: _____
List any medicines, foods, latex, etc. that you are allergic to and the reaction you have: _____

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/prostate/colon cancer _____
☐	☐	Heart attack_____
☐	☐	Stroke_____
☐	☐	Diabetes_____
☐	☐	Birth defects_____
☐	☐	Alcohol/drug abuse _____

Your Nutritional History

Yes	No	
☐	☐	Are there changes you would like to make to your diet? If yes, describe_____
☐	☐	Are you on a special diet? (e.g. vegetarian, diabetic) If yes, please describe _____
☐	☐	Do you exercise regularly? Describe_____
		List other supplements, vitamins herbs or weight loss preparations you use: _____
		Is your weight: __ just about right __ too heavy ____too thin?

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: _____
☐	☐	Heart disease, high blood pressure
☐	☐	Blood clots in arms/legs/chest
☐	☐	Heart attack or stroke
☐	☐	High cholesterol/triglycerides
☐	☐	Cancer: What type? _____When?_____
☐	☐	Blood problems (Sickle cell anemia, hemophilia, low iron)
☐	☐	Have you or your partner ever had a blood transfusion, tissue/organ transplant or artificial insemination? What year?_____
☐	☐	Surgery - List type and date _____
☐	☐	Liver disease (hepatitis, mono, jaundice, cirrhosis)
☐	☐	Diabetes
☐	☐	Depression or emotional problems
☐	☐	If you were born before 1975, did your mother take DES when she was pregnant with you?

Immunization History (list dates(s))

☐	☐	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_____

Over

Your Reproductive History

Yes	No	
☐	☐	Have you ever caused a pregnancy? If yes, how many children do you have? _____
☐	☐	Do you plan a pregnancy in the future?
☐	☐	Are you using birth control? Please check the birth control methods you use: □ Condoms □ Vasectomy □ Rely on partner's method. What method does your partner use?_____

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 in the past a lesion, sore, or lump on you scrotum or testicles? Describe_____ When?_____
☐	☐	Do you do Testicular Self Exam?

Have you ever had any of the following infections?

☐ Chlamydia	☐ Gonorrhea
☐ Syphilis	☐ Herpes
☐ Genital warts/HPV	☐ Trichomoniasis

Your Personal History

Yes	No	
☐	☐	Do you smoke cigarettes? How many cigarettes a day?____ Smokeless tobacco?_____
☐	☐	Do you drink alcohol? How many drinks a day?_____ week?_____
☐	☐	Do you ever feel you should cut down on your drinking?
☐	☐	Are you using any street drugs? (Ecstasy, meth, weed, etc.)
☐	☐	Are you using prescription medication not prescribed for you?
☐	☐	Have you or your sexual partner(s) ever used needles for drugs? (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? _____
☐	☐	Are you HIV positive?
☐	☐	Have you ever been forced to have sex?
☐	☐	Have you ever been hit, slapped, kicked, shaken or hurt by anyone?
☐	☐	Is there anyone who makes you feel unsafe now?
☐	☐	Have you had a new partner in the last 2 months?
☐	☐	Does your sex partner have other partners?

1. How many sexual partners have you had in the last 2 months?__
2. How many sexual partners have you had in the last year? _____
3. Are your sex partner's male _____ female _____ both _____?
4. Do you have oral sex_____ vaginal sex_____ anal sex_____?
5. When was the last time you had sex? _____

_____
Client signature

_____
Staff signature

Community Health Services

FAMILY PLANNING PROGRAM/STD INITIAL HISTORY AND EXAM FORM MALE/FEMALE

DATE:_____ **Preferred F/U Contact**:_____

REASON FOR VISIT:_____

SYMPTOMS:_____

Tests ordered: HSV_____ HIV: _____CT:_____ GC: _____ RPR: _____

Notes/Other:_____

_____

Education: Adolescent Counseling___ Contraceptive___ Breast Health Ed___ Cervical Health ED___
Pre-concept Counseling____ Preg. Options___ Delayed Exam___ Reprod Life Plan___ Diabetes___ STD/HIV___
Sexual Coercion___ Substance Abuse___ Emergency Contraception____ Nutrition/Weight loss/CA____
MMR/Tdap/FLU/HPV____ Counseling/psychiatric care ____ Suicide prevention_____
__ Smoke/Tobacco Y N If yes, Interest in quit Y N
__WWC 40-50 yr. Counsel Screening Mammo/Declined
QUITLINE Info provided? Y N Referral made? Y N

Method of Birth Control: Relies on Partner _____Condoms _____ OCP's _____ IUD _____ Nuvaring_____

Nexplanon/Implant_____ Diaphram _____ DepoProvera _____ Abstinence_____ Spermacide _____
Sterilization _____ Other_____

Nursing Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Order: _____

RX#:_____**Lot #** _____**EXP**_____

Referral: _____**RTC:** _____

Provider Signature: _____/_____**Date:** _____