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 ❑ 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

REQUEST FOR PREGNANCY TEST

Please Print

DATE_____/_____/_____
NAME_____ Birth Date___/____/___ AGE_____
ADDRESS_____ PHONE_____
CITY_____ STATE_____ ZIP_____

RACE: PLEASE MARK ALL THAT APPLY	How do you feel about becoming pregnant (Check the best answer)?
____African –American (Black) ____American Indian/Alaskan Native ____Asian ____Caucasian ____Pacific Islander ____Other **ETHNICITY:** Hispanic: __Yes__No	1.____I wanted to be pregnant sooner 2.____I wanted to be pregnant later 3.____I wanted to be pregnant now 4.____I didn't want to be pregnant

1. Any symptoms of pregnancy? _____Yes _____No If yes, list any symptoms_____
2. First day of your last period _____
3. Was it a normal period? _____Yes _____No
4. When was your last act of intercourse? _____
5. Check the method of birth control used: □Pill □Shot □Condoms □Implant □IUD □Patch

   □Ring □None □Other_____
6. If the result of the pregnancy test is negative, are you interested in a method of birth control?
   _____Yes _____ No
7. If you are pregnant, do you want a referral for: _____ Prenatal Care _____ Abortion
   _____ Adoption _____Unsure
8. Who do you see when you get sick?_____
9. How many pregnancies have you had? _____ How many births have you had? _____

   How many miscarriages? _____ How many abortions? _____
10. Do you smoke cigarettes? _____Yes _____ No
11. Number in household _____
12. Household annual income _____

I request that this clinic provide me with a pregnancy test. I understand if my test is positive, I should have a pelvic exam as soon as possible (within 15 days). If the test is positive, I will give a copy of this form to my healthcare provider.

_____ _____
Client Signature Date

CLINICAL DOCUMENTATION

Pregnancy Test	Reason Test Not Done	Test Results	Chlamydia/Gonorrhea Test Done
☐ Yes ☐ No	☐ Date of LMP too recent ☐ Client left ☐ Other _____	☐ Negative ☐ Positive LMP: _____ EDC: _____ Gestational Age: _____	☐ Yes ☐ No

Referral To	Service Provided	Education Given
☐ Family Planning Clinic appt. made:_____ ☐ Repeat Pregnancy Test: Date ☐ Prenatal Care ☐ Adoption services ☐ Abortion Services ☐ Nurse Family Partnership ☐ Prenatal Plus ☐ Medicaid/PE ☐ WIC ☐ Public Health Nurse ☐ STD Clinic ☐ Substance Abuse Program ☐ Smoking Cessation	☐ Pregnancy Test ☐ Pelvic Exam ☐ Counseling – Contraceptive/RLP ☐ Counseling – Adolescent (including abstinence, avoiding coercion, family involvement, and confidentiality) ☐ Counseling - Emergency Contraception ☐ Counseling - Pregnancy Options ☐ STD Counseling ☐ Dispensed Condoms and/or foam ☐ Depo_Provera Injection _____ ☐ Dispensed OCP's # ___ □ Quickstart ☐ Dispensed Evra (patch) □ Quickstart ☐ Dispensed NuvaRing □ Quickstart ☐ Dispensed prenatal vitamins/instructions	☐ AIDS/ Safe Sex ☐ All methods/E.C ☐ Anatomy/Menstrual Cycle ☐ Comfort measures/ pregnancy ☐ Drug/Alcohol/Smoking Risks ☐ Exercise ☐ Ectopic Precautions ☐ E.R. #'s: ☐ Folic Acid/Nutrition ☐ Medication during pregnancy ☐ Preconception Counseling ☐ Prenatal Depression ☐ Cramping/Bleeding ☐ Toxoplasmosis

☐ Family Planning Program Consent Signed

Objective Findings:

Bp: _____ Weight: _____

Pelvic (if indicated): _____

Other comments: _____

Chlamydia Test (circle one) Positive Negative N/A

Gonorrhea Test (circle one) Positive Negative N/A

_____ _____

Staff Signature Date