WOMEN'S HEALTH
BOULDER VALLEY WOMEN'S HEALTH CENTER

Today's Date: _____

Legal Name: _____ Name:_____

Date of birth: _____ Age: _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip: _____ County: _____

Is it OK to send mail to this address? ☐ **Yes** ☐ **No** If you have an outstanding balance after your visit or owe towards your insurance, we will mail statements to your address regardless of your preference.

Cell phone: _____ Message OK? ☐ Yes ☐ No Text OK? ☐ Yes ☐ No

Other phone: _____ Message OK? ☐ Yes ☐ No We will contact you on your cell phone first unless you tell us otherwise

Email: _____ Email OK? ☐ Yes ☐ No

How did you hear about us?

☐Another Doctor/Clinic who? _____
☐Friend/ Family
☐Community fair/festival which?_____
☐My Insurance
☐WIC / TANF / SNAP / GENESIS
☐Social Media where? _____
☐Newspaper or Bus Ad
☐Presentation where? _____
☐Google or other Search
☐Other_____

Sex Assigned at Birth	Preferred Language	Relationship Status	Student Status
☐ Female	☐ English	☐ Annulled	☐ Full Time Student WHERE?
☐ Male	☐ Spanish	☐ Divorced	☐ Not a Student
☐ Intersex	☐ Arabic	☐ Separated	☐ Part Time Student WHERE?
	☐ Czech	☐ Life Partner	
Gender	☐ German	☐ Married / Civil Union	
☐ Woman	☐ Hindi	☐ Polyamorous	
☐ Man	☐ Mandarin	☐ Single	
☐ Transgender	☐ Nepali	☐ Widowed	
☐ _____	☐ Other: _____		

Pronouns	Race- check at least one	Ethnicity	Sexual Orientation
☐ She / Her	☐ Asian or Asian American	☐ Hispanic or Latino/a	☐ Gay
☐ He / His			☐ Lesbian
☐ Ze / Zhr	☐ Native Hawaiian or Pacific Islander	☐ Not Hispanic or Latino/a	☐ Bisexual
☐ They / Them			☐ Heterosexual/Straight
☐ _____	☐ Black or African American	☐ I don't want to respond	☐ Queer
			☐ Pan/Omni
	☐ American Indian or Eskimo		☐ Questioning
	☐ White / Caucasian		☐ I don't want to respond
	☐ I don't want to respond		☐ _____

EMERGENCY CONTACT (ALL PATIENTS)

Name _____ Relationship _____

***If you are under 18**, you must list a parent or guardian. In Colorado, the law states that minors can access birth control and STI-related services without parental notification or consent.* **Do your parents/guardian know you receive services here?** ☐ **Yes** ☐ **No**

Telephone _____ **Does this person know you receive services here?** ☐ **Yes** ☐ **No**
Is it OK to contact this person if we can't reach you? ☐ **Yes** ☐ **No**

Comprehensive Health History Form

Legal Name:

Name:

Today's date: _____

Birth date: _____ **Age:** _____

Allergies (please list all of your allergies to medications, foods, latex, etc)

_____

Reason for Visit Today

_____

_____

**Please describe active concerns/symptoms.
**Multiple reasons may require separate appointments.

Your Medical History

Current prescription medications: None ☐

_____

_____

Over the counter medications, herbs, or supplements: None ☐

_____

_____

Yes	No	Do you now have or have you had any of the following?
☐	☐	High blood pressure
☐	☐	Blood clots (arms/legs/chest)
☐	☐	Heart attack or stroke
☐	☐	High cholesterol/triglycerides
☐	☐	Migraines (with visual changes)
☐	☐	Lupus (SLE)
☐	☐	Cancer: What type? _____ When? _____
☐	☐	Blood problems (ie sickle cell anemia, hemophilia, low iron)
☐	☐	Gall bladder disease
☐	☐	Surgeries - List type and date: _____ _____
☐	☐	Thyroid problems
☐	☐	Breast disease
☐	☐	Colon or colorectal problems
☐	☐	Colonoscopy - date:_____
☐	☐	Kidney or bladder problems (ie infections, UTI)
☐	☐	Liver disease (ie hepatitis, mono, jaundice, cirrhosis)
☐	☐	Diabetes
☐	☐	Epilepsy or convulsions
☐	☐	Osteoporosis
☐	☐	Depression or other mental health issues
☐	☐	Addiction
☐	☐	HIV
☐	☐	Any other medical conditions _____

Family Medical History ☐I'm adopted

Yes	No	Have your parents, siblings, grandparents, or aunts/uncles had any of the following?
☐	☐	Blood clots in arms/legs/chest
☐	☐	Bleeding problems
☐	☐	High blood pressure
☐	☐	High cholesterol/triglycerides
☐	☐	Breast/ovarian/uterine/colon cancer (please circle)
☐	☐	Heart attack
☐	☐	Stroke
☐	☐	Diabetes
☐	☐	Birth defects
☐	☐	Alcohol/drug abuse
☐	☐	Osteoporosis

Note: If you are under 18, we are required by law to report any case of sexual assault or abuse that has not already been reported.

Your Personal History

Yes	No	
☐	☐	Do you smoke or use tobacco currently? What type? _____ How much per day?_____
☐	☐	Have you used tobacco in the past? When did you quit? _____
☐	☐	Do you drink alcohol? How many drinks a day?____ Per week?_____
☐	☐	Do you use marijuana? How often? _____
☐	☐	In the past year, have you used an illegal drug or a prescription drug for non-medical reasons?
☐	☐	Have you ever been hit, slapped, kicked, shaken, or hurt by anyone?
☐	☐	Have you ever been forced to engage in sexual activities?

Nutrition

Yes	No	
☐	☐	Are you happy with your weight and diet? If no, describe:_____
☐	☐	Do you exercise regularly? Describe: _____

Immunizations

Yes	No	Don't Know	
☐	☐	☐	Are you up to date on vaccines?
☐	☐	☐	HPV (human papilloma virus) vaccine? Date_____
☐	☐	☐	Flu vaccine? Date_____

Over

Your Reproductive and Sexual Health

Female/Assigned Female at Birth ☐ I've had SRS

Do you want to become pregnant in the next year? ☐Yes ☐No

Your Menstrual History

Age of first period _____

First day of your last period: _____, or:

☐ I don't get a period due to hormones, an IUD, or an implant

☐ I'm post-menopausal, and it was: ☐Natural ☐Surgical

Year of menopause _____

Yes	No	
☐	☐	Do you get a period every month? Is the flow: ☐light ☐medium ☐heavy
☐	☐	Do you have cramps with your periods?

Your Pregnancy History

How many times have you been pregnant? _____, or: ☐Never

Age at first birth?_____

How many living children do you have? _____

Dates of any vaginal births:_____

Dates of any C-sections:_____

Dates of any miscarriages:_____

Dates of any abortions: _____

Dates of any tubal pregnancies: _____

Are you breast-feeding now? ☐Yes ☐No

Yes	No	
☐	☐	Have you had a baby that weighed less than 5 1/2 pounds at birth? _____
☐	☐	Have you had a baby that weighed more than 9 pounds at birth? _____
☐	☐	During pregnancy, have you had high blood pressure, diabetes, or a baby with birth defects? _____

Your Gynecological History

When was your last Pap test? _____ ☐Never

When was your last mammogram? _____ ☐Never

Yes	No	Have you had any of the following?
☐	☐	Abnormal Pap test? When? _____
☐	☐	Abnormal mammogram? When? _____
☐	☐	Biopsy or treatment of your cervix: When? _____
☐	☐	Ovary problems
☐	☐	Uterus problems or uterine fibroids
☐	☐	Pelvic Inflammatory Disease (PID)
☐	☐	Vaginal infections (yeast or bacterial vaginosis)

If born before 1970, did your mother take DES? ☐Yes ☐No

Your Birth Control History

How do you prevent pregnancy? _____

Yes	No	
☐	☐	Have you used any birth control methods that you have had a problem with? What method(s)?_____
☐	☐	In the last 5 days or since your last period, have you had sex without birth control (includes condoms)? When? _____

ALL PATIENTS

Have you ever had any of the following:

Yes	No	
☐	☐	Chlamydia
☐	☐	Gonorrhea
☐	☐	Genital warts/Human Papilloma Virus/HPV
☐	☐	Syphilis
☐	☐	Genital Herpes
☐	☐	Trich
☐	☐	Have you or your sexual partner(s) ever used needles to shoot drugs?
☐	☐	Have you or your sexual partner(s) ever exchanged sex for drugs or money?
☐	☐	STI testing? When? _____
☐	☐	HIV test? When? _____
☐	☐	Have you had a new partner in the past 3 months?
☐	☐	Does your sex partner have other partners?

How do you protect yourself from STIs? _____

1. How many sex partners have you had in the past 3 months? _____

2. How many sex partners have you had in the past year? _____

3. My sex partner(s) have a: ☐Penis ☐Vagina ☐ _____

4. What kind of sex do you have:
   ☐Vaginal ☐ Oral ☐Anal ☐ _____ ☐ None

5. When was the last time you had sex? _____

6. Have any of your male partners had sex with other males?
   ☐Yes ☐No ☐Don't know ☐N/A

Male/Assigned Male at Birth ☐ I've had SRS

Yes	No	
☐	☐	Do you have abnormal discharge from the penis now? Describe: _____
☐	☐	Do you have now or in the past a sore or lump on your penis, scrotum or testicles? Describe:_____ When?_____

Your Reproductive History

Yes	No	
☐	☐	How many children do you have? _____
☐	☐	Do you want children in the future? _____

How do you prevent pregnancy?_____

PATIENT SIGNATURE: _____

DATE: _____

Provider Initials: _____ Date: _____

WOMEN'S HEALTH
BOULDER VALLEY WOMEN'S HEALTH CENTER

Today's date: _____

Please answer the following questions by circling Yes or No:

1. Over the past two weeks, have you often had little interest or pleasure in doing things? Yes No

2. Over the past two weeks, have you often been bothered by feeling down, depressed, or hopeless? Yes No

- If you answered "NO" to both questions, you do not need to fill out any more information on this form.
- If you answered "YES" to either one or both questions, please answer the remaining questions. You will be able to discuss the answers you provide with your clinician today.

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please circle the appropriate response for each question.)

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way?	0	1	2	3

2017 Insurance & Payment Policies

Billing→Other→2017 Financial

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BOULDER VALLEY WOMEN'S HEALTH CENTER

Please complete this form as accurately as possible. If you have questions, please let us know.

☐ 1 **I don't have insurance. I would like to find out if I am eligible for insurance or a discount.**
If you are eligible for health insurance, we ask that you meet with our enrollment specialist prior to receiving services. Please present proof of income along with this form. Services are not available at a discount without income verification.

☐ 2 **I have health insurance that can be used at Women's Health. I request that you bill my insurance company directly.**
Co-pays and deductibles or coinsurance prepayments may be required. It is your responsibility to verify with your insurance company that we are an in-network provider for your plan, if applicable.

☐ 3 **I have health insurance, but I choose not to use it.**
Note: if you are between the ages of 18 to 26 and are not using your parent/guardian's insurance due to confidentiality concerns, you may be eligible for our sliding fee scale. Please speak with a staff member to determine if the services you're requesting could be discounted. You must present proof of income along with this form.

☐ 4 **I am not using insurance and prefer not to declare my income. I agree to pay the full rate for all services.**
Payment is due at the time of service. We are able to offer a "pay today" discount for most services.

☐ 5 **I am 19 years of age or younger, and I don't want my parent(s)/guardian to know I receive services here or am uninsured.**
Women's Health keeps any and all information about you and the services you receive here strictly confidential as required by law. If you are accessing abortion care, the State of Colorado requires parental notification; however there are exceptions that may apply. Please ask a staff member if this is an issue for you.

Payment for services:

Payment is due at the time of service, including co-pays and deductibles. Accepted methods of payment include: cash, credit cards (Visa, MasterCard, or Discover), checks (for some services), and money orders. If you pay by check and the check is returned for insufficient funds, an additional $20 service charge will be added to your balance. If you are not using insurance, please know that our quotes are estimates; the cost of your appointment may change with changes in your income information or the services you receive.

All patients: Please document all sources of pre-tax income so that we can make sure that you are not overcharged. *Even if you are using insurance, please provide your income information. Some services are eligible for further adjustments in the event that your insurance does not pay.*

Are you employed? No ☐ Yes ☐ Occupation: _____

Personal income: Hourly rate $_____ average hours worked / week _____ **or** Annual salary $_____

Partner/spouse income: Hourly rate $_____ average hours worked / week _____ **or** Annual salary $_____

I have the following additional income:

☐ Unemployment benefits $_____/month
☐ Parental or Family Support (for rent, bills etc.) $_____/month
☐ Savings/Inheritance (trust fund, etc.) $_____/month
☐ Child Support/Alimony $_____/month
☐ Disability or Social Security $_____/month
☐ Other _____ $_____/month

How many people, *including you*, are supported by the reported income? _____

STAFF USE ONLY

Quarter 1 2 3 4 Verified by: _____

Calculated personal income: _____ month / year

Calculated partner income: _____ month / year

Additional income: _____ month / year

TOTAL INCOME: _____ month / year

Income Level 1 | 2 | 3 | 4 | 5 | Insured

01/2017

OVER →→→→→

Insurance:

If you are using insurance, be aware that complete confidentiality of information related to your visit cannot be assured. This is because a statement of your services will normally be sent to the insurance carrier and to your address on file with the insurance company. If you want these statements to go to a different address, it is your responsibility to contact your carrier directly. If you have a balance after we have billed your insurance, we will send a statement to your address.

Many insurance companies have limitations that may affect your coverage. It is your responsibility to know what healthcare services are covered by your particular insurance policy. This includes requirements and policies regarding: referrals, prior authorizations, co-payments, co-insurance, deductibles and benefits. Questions about your coverage should be directed to your insurance plan administrator. **The staff and providers at Women's Health do not know what is or is not covered under your specific plan.**

You are required to pay your co-pay at the time of service. We may also require you to pay a portion of your deductable or co-insurance if your insurance company says that you owe one. After we bill your insurance company, you are responsible to pay any amount not covered by your insurer. If your insurance carrier denies your claim, you will be responsible for your account balance in full.

Please Initial Below:

_____ I request and assign all payments of authorized benefits be made on my behalf to Boulder Valley Women's Health Center (BVWHC) for any services that I receive. I authorize BVWHC to file appeals on my behalf for any denial of payment.

_____ I understand that not all services are covered under all health plans. **If my health plan does not cover a service or procedure, or if my visit is subject to a deductible or coinsurance it is my responsibility to pay for those charges**. During the course of your care we may recommend additional tests or services—these may result in additional charges.

_____ I understand that some routine screenings, including but not limited to: contraceptive management, urinalysis and certain injections may not be covered by some insurance carriers. **I understand and agree that I will be responsible to pay for services that are not paid by my insurance company.**

_____ I understand that all outside lab charges (blood work, cultures, biopsies and pathology) are not included with my office visit and will be billed to my insurance separately by the laboratory. The laboratory will bill you/your insurance according to its fee schedule which Women's Health has no control over. Women's Health is not responsible for these charges.

Please fill out the following information about your insurance policies. Present your insurance card to the front desk at each visit.

Primary Insurance Company name: _____

Subscriber/Member Number: _____ Group Number: _____

Whose insurance policy is it?: ☐ Mine ☐ Parent's ☐ Spouse/Partner ☐ Guardian ☐ Other _____

Policy Holder's Name: _____ Date of Birth: _____ SSN: XXX-XX-_____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance Company name: _____

Subscriber/Member Number: _____ Group Number: _____

Whose insurance policy is it?: ☐ Mine ☐ Parent's ☐ Spouse/Partner ☐ Guardian ☐ Other _____

Policy Holder's Name: _____ Date of Birth: _____ SSN: XXX-XX-_____

Address: _____ City: _____ State: _____ Zip: _____

ALL PATIENTS, SIGN BELOW:

Your signature indicates that you have read and agree to the above financial policy. You are certifying that the information you have provided is accurate to the best of your knowledge.

Printed name: _____ Signature: _____ Date: _____

OVER →→→→→