TODAY'S DATE: _____

WOMEN'S HEALTH
BOULDER VALLEY WOMEN'S HEALTH CENTER

NAME:		**LEGAL NAME:** (used for insurance purposes)	
DATE OF BIRTH:	**AGE:**		
ADDRESS:			
CITY:	**STATE:**	**ZIP CODE:**	**COUNTY:**
Is it okay to send mail to this address? ☐Yes ☐No	You will receive statements in the mail if a balance remains after your visit regardless of the preference indicated here.		

PATIENT CELL PHONE:	Detailed Voicemail ok? ☐Yes ☐No	Text ok? ☐Yes ☐No	
OTHER PHONE:	Detailed Voicemail ok? ☐Yes ☐No	We will contact you on your cell phone first unless you tell us otherwise.	
EMAIL:	For Patient Portal Registration		

SEX ASSIGNED AT BIRTH	**GENDER**	**PRONOUNS**
☐Female ☐Male ☐Intersex ☐"X" or None Assigned	☐Woman ☐Genderqueer ☐Nonbinary ☐Genderfluid ☐Man ☐Agender ☐Trans ☐	☐She/Her/Hers ☐They/Them/Theirs ☐He/Him/His ☐No pronouns ☐Ze/Zir/Zirs ☐
LANGUAGE(S)	**RACE**	**ETHNICITY**
☐English ☐Mandarin ☐Spanish ☐Nepali ☐Arabic ☐Portuguese ☐Russian ☐ ☐Hindi	☐Asian/Asian American ☐Native Hawaiian/Pacific Islander ☐Black/African American ☐American Indian/Eskimo ☐White/Caucasian	☐Not Hispanic/Latinx ☐Hispanic/Latinx
CIVIL STATUS	**SEXUAL ORIENTATION**	**MIDDLE SCHOOL/HIGH SCHOOL**
☐Single ☐Married/Civil Union ☐Domestic Partner/Life Partner ☐Divorced ☐Annulled ☐Legally Separated ☐Widowed ☐Polygamous ☐	☐Straight/Heterosexual ☐Lesbian or Gay ☐Bisexual ☐Pansexual or Omnisexual ☐Asexual ☐Queer ☐Questioning ☐	☐I am a middle school or high school student Where? _____

EMERGENCY CONTACT Must be a parent or guardian if you are under 18.

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

NAME:_____ **RELATIONSHIP TO YOU:**_____

Does the emergency contact know you receive services here? ☐Yes ☐No

PHONE:_____ **May we contact this person if we can't reach you? ☐Yes ☐No**

FIRST VISIT? HOW DID YOU HEAR ABOUT US?

☐Another Doctor/Clinic – Who? _____	☐Community Fair/Festival – Which? _____
☐Friend/Family Member	☐Social Media – Where? _____
☐My Insurance	☐Newspaper or Bus Ad
☐WIC/TANF/SNAP/GENESIS(TER)	☐Presentation – Where? _____
☐Searched online/Googled	☐Other – Where? _____

COMPREHENSIVE HEALTH HISTORY FORM

DATE: _____

NAME:

LEGAL NAME:
(name for billing)

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, 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 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
Your 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 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 sexual partners have you had:
   in the past 3 months? _____
   in the past year? _____

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

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

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

5. 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	
☐	☐	Do you have children? How many? _____
☐	☐	Do you want children in the future? _____

How do you prevent pregnancy? _____

PATIENT SIGNATURE: _____

TODAY'S DATE: _____

PROVIDER SIGNATURE: _____ **DATE:** _____

2019 INSURANCE AND PAYMENT POLICIES

WOMEN'S HEALTH
BOULDER VALLEY WOMEN'S HEALTH CENTER

CHOOSE ONE:

☐ 1 **I DO NOT HAVE INSURANCE AND I WOULD LIKE TO KNOW IF I AM ELIGIBLE FOR INSURANCE OR A DISCOUNT.**
If eligible for insurance, please meet with our enrollment specialist before receiving services. Proof-of-income is required for enrollment and discounts.

☐ 2 **I HAVE HEALTH INSURANCE THAT CAN BE USED AT WOMEN'S HEALTH. I REQUEST THAT YOU BILL MY INSURANCE DIRECTLY.**
Present insurance card to front desk. Co-pays and deductible/co-insurance prepayments may be required. It is your responsibility to verify with your insurance company that we are an in-network provider for your specific plan.

☐ 3 **I HAVE HEALTH INSURANCE BUT I CHOOSE NOT TO USE IT. I AGREE TO PAY THE FULL RATE FOR ALL SERVICES.**
Payment is due at time-of-service. Let us know if insurance is a confidentiality issue for you.

☐ 4 **I DO NOT HAVE INSURANCE AND I DO NOT WANT TO DECLARE MY INCOME. I AGREE TO PAY THE FULL RATE FOR ALL SERVICES.**
Payment is due at time-of-service.

☐ 5 **TEEN CLINIC SLIDING SCALE: I AM LESS THAN 20 YEARS OLD AND I DON'T WANT MY PARENT(S)/GUARDIAN TO KNOW I RECEIVE SERVICES HERE OR I DON'T HAVE INSURANCE.** Teen discounts not available for abortion care.
☐ I have private insurance ☐ I have Medicaid ☐ I do not have insurance

PAYMENT FOR SERVICES:

Payment is due at time-of-service, including co-pays and deductibles payments. We accept cash, credit cards (Visa, MasterCard, Discover, AmEx), checks (for some services), and money orders. Returned check fee is $20. Please note that all quotes are estimates; final appointment cost may change with changes in income information or services received. Statements will be sent to your address for all unpaid balances, so please discuss confidentiality concerns with staff before your visit.

PRE-TAX INCOME INFORMATION

Even if you have insurance, please provide income information. You may be eligible for discounts if your insurance does not cover all charges.

ARE YOU EMPLOYED? ☐ No ☐ Yes - Occupation: _____

PERSONAL IMCOME: Hourly rate $_____ Average hours worked per week _____ OR Annual salary $_____

PARTNER'S INCOME: Hourly rate $_____ Average hours worked per week _____ OR Annual salary $_____

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, DOES THE REPORTED INCOME SUPPORT? _____

STAFF USE ONLY

Calculated personal income: _____ month / year
Calculated partner income: _____ month / year
Additional income: _____ month / year
TOTAL INCOME: _____ month / year

Quarter: 1 2 3 4 Verified by: _____
Verification? Yes No
Type of verification/reason: _____
Code: 1 2 3 4 5 Insured

☐ Client refused to report/does not want to be considered for sliding scale

Over

CONFIDENTIALITY WITH INSURANCE

Confidentiality is not guaranteed for services charged to your insurance company, especially if you are not the policy holder. The insurance company may send a summary of charges to the address they have on-file. If you want these statements to go to a different address, you must contact your insurance company directly. We will send a statement to your address for any balance remaining after we have billed your insurance.

COVERAGE WITH INSURANCE

Our staff do not know which services are covered by your insurance. It is your responsibility to verify covered services for your specific plan/policy. This includes requirements, limitations, and policies regarding referrals, prior authorizations, co-payments, co-insurance, deductibles, and benefits. Please direct questions about coverage to your insurance plan administrator.

PAYMENT WITH INSURANCE

Co-pays, deductible payments, and co-insurance payments are due at time-of-service. You are responsible for any outstanding balance that remains unpaid by your insurance. If the insurance carrier denies your claim, you are responsible for the account balance in full and a statement will be mailed to your address.

INSURANCE USERS INITIAL BELOW:

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

_____ I understand that there are services my insurance plan may not cover, including but not limited to screenings like contraceptive management, urinalysis, and certain injections. If my insurance does not cover a service or procedure, or if my visit is subject to a deductible/co-insurance, I am responsible for any unpaid charges. I understand that my provider may recommend additional services or tests and that they may result in additional charges.

_____ I understand that all outside lab charges (blood work, cultures, biopsies, and pathology) are not included with my visit and that the laboratory will bill my insurance separately. Women's Health does not know or control laboratory prices, and I, not Women's Health, am responsible for these charges.

INSURANCE POLICY INFORMATION

Primary Insurance Company Name: _____

Subscriber/Member Number: _____ Group Number: _____

Whose policy is it? ☐Mine ☐Parent/Guardian ☐Spouse/Partner ☐Other _____

Policy Holder's Name: _____ Date of Birth: _____

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

Secondary Insurance Company Name: _____

Subscriber/Member Number: _____ Group Number: _____

Whose policy is it? ☐Mine ☐Parent/Guardian ☐Spouse/Partner ☐Other _____

Policy Holder's Name: _____ Date of Birth: _____

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

ALL PATIENTS

I have read and agree to this financial policy. The information I provided is accurate to the best of my knowledge.

NAME: _____ **SIGNATURE:** _____ **DATE:** _____

Over

FAMILY PLANNING PROGRAM CONSENT FORM

WOMEN'S HEALTH
BOULDER VALLEY WOMEN'S HEALTH CENTER

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 testing (if indicated), 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 they understand it.

_____ _____
Signature of staff Date

Interpreter identification information _____

Boulder Valley Women's Health Center | 2855 Valmont Rd (Boulder) & 82 21st St (Longmont) | Phone: 303-440-5160