Colorado Obstetrics & Women's Health

PLEASE PRINT CLEARLY

Patient Demographics

CURRENT LEGAL NAME _____ (Last) _____ (First) _____ (MI)

OTHER NAME USED _____ (Last) _____ (First) _____ (MI)

Mailing Address _____ (Street) _____ (Apt No.) _____ (City) _____ (State) _____ (Zip)

Home #: ( ) _____ Cell #: ( ) _____ Work#: ( ) _____ Detailed Voicemail OK? Yes or No

Date of Birth: _____ Age: _____ Alternate #: _____ SSN: _____

Marital Status: M D S W Student? Yes or No School: _____

Employer: _____ Title: _____

Pharmacy name & phone # _____ Primary Care Physician & Phone #: _____

SPOUSE OR PARENT/GUARDIAN INFORMATION

LEGAL NAME _____ (Last) _____ (First) _____ (MI)

Mailing Address _____ (Street) _____ (Apt No.) _____ (City) _____ (State) _____ (Zip)

Preferred #: ( ) _____ Alternative #: ( ) _____ Detailed Voicemail OK? Yes or No

Date of Birth: _____ Age: _____ SSN: _____

Employer: _____ Title: _____

INSURANCE INFORMATION

PRIMARY INSURANCE (If Tricare, please specify Prime/Standard, and complete the sponsor/subscriber info)

Company Name _____ Effective Date: _____

Mailing Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Telephone: _____ ID #: _____ Group #: _____

Subscriber _____ (Last) _____ (First) _____ (MI)

Date of Birth: _____ Subscriber SSN: _____

Employer: _____ Relationship to Subscriber _____

SECONDARY INSURANCE

Company Name _____ Effective Date: _____

Mailing Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Telephone: _____ ID #: _____ Group #: _____

Subscriber _____ (Last) _____ (First) _____ (MI)

Date of Birth: _____ Subscriber SSN: _____

Employer: _____ Relationship to Subscriber _____

I herby authorize payment of surgical and/or medical benefits if any, otherwise payable to me, directly to Colorado Obstetrics & Women's Health for services rendered. I understand that I am responsible for all Medical Bills incurred and all collection expenses that may become necessary to collect those bills. By my signature, I understand and agree to the terms set forth therein.

Patient Signature: _____ **Date:** _____

I herby authorize the release of pertinent medical information in the possession of the physician to my insurance agency listed above for the processing of and insurance claims.

Patient Signature: _____ **Date:** _____

FOR EXISTING PATIENTS: In lieu of filling out a new patient information sheet, please verify your address and insurance information is the same as shown above. I have reviewed the above information and I hereby certify, by signing and dating this document, that the above information is true and accurate.

Patient Signature: _____ **Date:** _____

3230 E. Woodmen Rd. Suite 100 * Colorado Springs, CO. 80920 * Phone (719) 634-8800 * Fax (719) 634-4474

Colorado Obstetrics & Women's Health

Responsibility Agreement

This is an agreement between Colorado Obstetrics & Women's Health and the responsible party.
Please read this document **CAREFULLY** and initial each section.

Late Policy (Physician):

All efforts are made to keep the physicians schedule on time; therefore, if you are more than 15 minutes late, every effort will be made to fit you into the schedule. There is no guarantee that you will be seen immediately. If your physician's schedule is full, you will be asked to reschedule your appointment. When the physician is called out for an emergency or a delivery of a baby, every effort is made to give you enough notice so that the appointment can be rescheduled. However, there may be times when you are present in the office and the appointment will need to be rescheduled. Every effort is made to accommodate your schedule when rescheduling your appointment. We appreciate your understanding.

Late Policy (Ultrasound): _____ *Initials*

All efforts are made to keep our sonographers schedule on time; therefore, we ask that you please arrive 15 minutes early for your appointment. If you are more than 15 minutes late, you will be asked to reschedule your appointment.

Missed Appointments: _____ *Initials*

If a patient is unable to attend a scheduled appointment, a 24 hour advance notification is required. Patients may leave a cancellation message with the answering service during the weekend or holiday hours. Otherwise, cancellations should be made during regular business hours. In case of extraordinary circumstances that arise within 24 hours of appointment, which prevent the keeping of an appointment, the patient is expected to call and inform the practice that she will be missing her appointment. Abusive missed appointments more than 3 (three) times will result in a $25.00 cancellation fee as of May 1, 2007. Continued abusive missed appointments may result in dismissal from the practice.

Payment Policy: _____ *Initials*

Our office will file the claims to your insurance carrier after your visit. After the claim has processed, the balance will be adjusted according to your contract. If there is a balance due, as determined by your insurance, you will be responsible to pay that balance upon notification. If the balance is not paid within 90 days, your account will be forwarded to a collection agency. As of July 1, 2007, Colorado Obstetrics & Women's Health will no longer be accepting checks as a viable method of payment. Payments may be made by cash, Visa, MasterCard, Discover, or American Express only. Payments made with a check prior to July 1, 2007 will be subject to a $25.00 fee for any checks returned by the bank. This fee is due when billed, or at the patient's next appointment, whichever comes first. If payment is not made prior to the appointment, you will be rescheduled.

Annual/Well Woman Exams: _____ *Initials*

Many insurance plans including Medicare and Medicaid do not cover routine preventive health services (that is physical examinations and other screening examinations). You need to be familiar with your particular plan's covered and non-covered services. Our physicians believe that yearly physical examinations are essential in providing you the best health care possible, regardless of your insurance benefits. Please understand that we will not code a preventive health visit as anything else in order to have your insurance pay. This is considered insurance fraud.

Referrals: _____ *Initials*

When your insurance plan requires a referral or authorization from your primary care physician, it is your responsibility to request and verify the initial referral has been received. Otherwise, your appointment may be rescheduled. You will be responsible for the payment of the office visit and any additional tests if the referral is not properly obtained.

Diagnostic Testing: _____ *Initials*

Please be aware that fees for diagnostic testing are in addition to the fees for the office visit.

I have read and I understand the above information. _____ *Initials*

Printed Name: _____

Signature: _____ **Date:** _____

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Colorado Obstetrics & Women's Health

Authorization for Release of Information

Patient Name _____ **DOB:** _____

An authorization for release of medical records authorizes our office to discuss and disclose medical information to designated individuals. You may permit individuals, other than yourself, access to this information. You may also deny other individuals from receiving this information.

Please check one of the two boxes listed below.

I would prefer that information *not* be given to anyone other than myself.

Patient Signature: _____ **Date:** _____

OR

I hereby authorize the release of information regarding my treatment at this office, including information regarding my illness, test results, and bills to the individuals listed below. I will hold Colorado Obstetrics & Women's Health harmless, for complying with this "Authorization for Release of Medical Information". I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law. I understand that disclosure of information to a party other than the one(s) listed below is forbidden without additional authorization on my part.

Name: _____ **Phone:** _____

Relationship to Patient: _____

Patient Signature: _____ **Date:** _____

Name: _____ **Phone:** _____

Relationship to Patient: _____

Patient Signature: _____ **Date:** _____

Name: _____ **Phone:** _____

Relationship to Patient: _____

Patient Signature: _____ **Date:** _____

Name: _____ **Phone:** _____

Relationship to Patient: _____

Patient Signature: _____ **Date:** _____

Colorado
Obstetrics &
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Authorization for
Specimen Collection

Dear Patient,

Your appointment today may require the collection of one or more specimens. All specimens will be sent to an outside laboratory for analysis. We will try to ensure that the specimen(s) are sent to a laboratory that is contracted through your insurance company. There will be outside fees associated with these procedures. Any laboratory fees will be billed to your respected insurance plan. You may receive a bill for those services provided by the laboratory.

Specimens that are collected and sent out for analysis include:

- Pap Smears (AmeriPath)
- Biopsies (AmeriPath, Gynecor for Colposcopies)
- Tissue Samples (AmeriPath, Gynecor for Colposcopies)
- Genital Culture(s) (Medical Diagnostic Labs, LabCorp, UCH Memorial)
- Urine Samples (LabCorp, UCH Memorial)
- Blood tests will be ordered for external collection @LabCorp & UCH Memorial

If there is **a particular** laboratory you would like your specimens forwarded to, please inform us during your visit today, and list below for future reference please:

I wish for my specimens to be sent to: _____

Reason(s) for specimens to be sent to this laboratory: _____

_____

_____

I have read and I understand the above information.

Printed Name: _____

Signature: _____ **Date:** _____

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