Avista
Women's Care

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PATIENT INFORMATION

Name: _____ **DOB:** _____ **Gender:** _____

Address: _____

Race: _____ Ethnicity: _____ SSN: _____-_____-_____

Marital Status: S M D W Sexual Orientation: _____ Preferred Language: _____

Preferred Phone: _____ **Alternate Phone:** _____

Employer: _____ Work Phone: _____

Email address: _____ PCP: _____

Who referred you to our practice? _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship to patient: _____ Phone: _____

PRIMARY INSURANCE INFORMATION

Subscriber/Policyholder: _____ DOB: _____

Subscriber's Address: _____

Relationship to patient: _____ Effective Date of Coverage: _____

Insurance Name: _____

IF NO CARD IS PROVIDED or NO ACCESS TO YOUR CARD, YOU WILL BE CONSIDERED SELF-PAY

********If you have secondary or tertiary insurance coverage, please provide valid insurance cards to the receptionist.*

***I authorize my insurance to pay medical benefits to Avista Women's Care for services provided. I authorize the release of any information/records necessary for my insurance to process my claims submitted by Avista Women's Care.*

_____ _____

Signature of Patient/Authorized Representative Date

Name:_____ DOB:_____ Date:_____

PATIENT MEDICAL HISTORY FORM

OBSTETRICAL HISTORY:

Pregnancies	
Deliveries	
Type of Delivery	
Abortions/Miscarriages	
Living Children	
Weight of largest baby (vaginal delivery)	

Pregnancy	*Date*	*Boy/Girl*	*Weight*	*Delivery Type*	*Weeks at Delivery*
Pregnancy #1					
Pregnancy #2					
Pregnancy #3					
Pregnancy #4					
Pregnancy #5					

GYNECOLOGICAL HISTORY

	Date	*Additional Information*
1st day of your last menstrual period		
Contraceptive use/(current)		Type:
Contraceptive use/(previous) (list all)		Type (list all):
Hormone replacement use (current)		
Hormone replacement use (previous)		
Date of your last Pap smear		
Date of your last Mammogram		
History of Abnormal Paps? (Circle) Yes No		*If yes, list treatment(s)*
History of Abnormal Mammogram? (Circle) Yes No		*If yes, list treatment(s)*
History of Sexually Transmitted Disease? (Circle) Yes No		
History of Rape, physical or sexual abuse? (Circle) Yes No		
OTHER SYMPTOMS OR CONCERNS:		*Please describe:*

Name:_____ Date:_____

MEDICAL HISTORY:

Please list all medical conditions, how long since you were diagnosed with the condition (s) and what medication (s) you take for the condition (s). (i.e., diabetes, high blood pressure, heart disease, asthma, kidney disease, ulcers, psychiatric illness, cancer, etc.)

1. _____
2. _____
3. _____

SURGICAL HISTORY:

Please list all surgeries (except cesareans), the year in which they were performed, the name of the hospital, city and state in which the surgery (ies) were performed.

1. _____
2. _____
3. _____

CURRENT MEDICATIONS:

Please list all prescriptions and over the counter medications you are currently taking, as well as dosage if known.

1._____ 2._____

3._____ 4._____

MEDICATION ALLERGIES:

Allergies to Medication and Reaction: _____

Do you use: Alcohol? Yes/No How often:_____ Type:_____

Do you use: Tobacco? Yes/No How much per day: _____ Ever try to quit? Yes/No When:_____

Other Drugs: _____ Frequency: _____

FAMILY HISTORY:

Please list any family history including but not limited to Cancer, Hypertension, Heart disease, Diabetes, etc. Please indicate how the family member is related (example: Maternal Grandmother, Paternal Grandfather, Paternal Aunt, etc.)

Family Member_____ History_____

Family Member_____ History_____

Family Member_____ History_____

Family Member_____ History_____

Family Member_____ History_____

AVISTA WOMEN'S CARE

Acknowledgment of Privacy Policy

Name of Patient (please print) **Date of Birth**

I hereby acknowledge that I received Avista Women's Care Privacy Policy.

Signature of Patient **Date**

Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received provider Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient)

The patient presented to the office on _____ and was provided with a copy of Avista Women's Care Privacy Policy. A good faith effort was made to obtain from the patient a written acknowledgment of her receipt of the Notice. However, such acknowledgment was not obtained for the following reason:

_____ Patient refused to sign

_____ Patient was unable to sign or initial because _____

_____ The patient has a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.

_____ Other reasons (please describe):

_____

_____

Signature of Employee Completing Form **Date**

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Today's Date: _____ **Health Care Provider:** _____

Instructions: This is a screening tool for cancers that run in families. Please mark Y for those that apply to YOU and/or YOUR BIOLOGICAL FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family. You and the following close blood family members should be considered:

- First-degree relatives: Mother, father, full siblings, or children
- Second-degree relatives: Grandparents, grandchildren, aunts, uncles, nephews, nieces or half-siblings
- Third degree relatives: First-cousins, great-grandparents, great uncle/aunt, great grandchildren

YOUR FAMILY'S Cancer History (Please be thorough and accurate)

	CANCER	YOU (age)	PARENTS / SIBLINGS / CHILDREN	AGE	MOTHER'S SIDE	AGE	FATHER'S SIDE	AGE
☐ Y ☐ N	*EXAMPLE: BREAST CANCER*		*Sister*	*41*	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐ Y ☐ N	BREAST CANCER							
☐ Y ☐ N	OVARIAN CANCER							
☐ Y ☐ N	UTERINE/ENDOMETRIAL CANCER							
☐ Y ☐ N	COLON/RECTAL CANCER							
☐ Y ☐ N	OTHER CANCER(S) (SPECIFY):							

☐ Y ☐ N Are you of Jewish descent?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome?
If yes, please explain and include a copy of the result:

Testing Criteria (FOR OFFICE USE ONLY....DO NOT FILL OUT)

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Breast cancer diagnosed ***UNDER*** age 50*
- ☐ Ovarian cancer at ANY age*
- ☐ Two primary breast cancers in the same person at ANY age*
- ☐ Two relatives on the same side of the family with breast cancer, one diagnosed at or under age 50**
- ☐ Three or more relatives on the same side of the family with any of the following cancers: breast, ovarian, pancreatic, prostate**
- ☐ Triple negative breast cancer at or under the age of 60 (receptor status negative for ER, PR and HER2)*
- ☐ Male breast cancer at ANY age*
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer***
- ☐ Metastatic prostate cancer*
- ☐ Personal history of metastatic breast cancer

Lynch Syndrome

- ☐ Colon/rectal cancer or endometrial cancer diagnosed at or under age 50*
- ☐ Two or more with a Lynch syndrome cancer****, one before the age of 50*
- ☐ Three or more with a Lynch syndrome cancer**** at any age*
- ☐ A previously identified BRCA1/BRCA2 mutation, Lynch syndrome or other genetic mutation in the family

* In self, first or second degree family members
**In self, first, second, or third degree family members
***HBOC associated cancer includes: *Breast, ovarian, and pancreatic cancer*
****Lynch-associated cancers include: *colon, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas.*

Cancer Risk Assessment Review and Counseling

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only:

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Appointment: _____

Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Avista Women's Care
Obstetrics and Gynecology

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HEALTH INFORMATION PERMISSION

Patient Name (please print)_____ DOB _____

I give permission to Avista Women's Care to release information to the following:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

You may disclose the following information: (check all that apply)

_____ Medical information which may include diagnoses and results

_____ Financial information which may include procedure descriptions and any past due amounts

Signed _____ Date _____

It is the patient's responsibility to update this form/information as needed.

12/2010

90 Health Park Drive. Suite 290
Louisville. CO 80027

303.439.8910 Phone
303.439.9134 Fax

1225 Cimarron Drive, Suite 101
Lafayette, CO 80026

OUR FINANCIAL POLICY

Updated 06/2016

- Copayments are due at the time of service. It is also your responsibility to obtain any referrals necessary for the Primary Care Provider prior to your appointment in our office. Failure to do so may result in your financial responsibility for the services provided.

- All visits or services that are applied to your deductible, or are not covered by your insurance are your financial responsibility, and must be paid within 21 days of your statement date. All accounts that are 90 days past due may be sent to an outside collection agency.

- It is your responsibility to know what your insurance will or will not cover. This includes laboratory services outside of Avista Women's Care. If you disagree with the way your insurance company processes a claim, you must pay the balance and submit an appeal to your insurance for a redetermination. We will refund any credits due back to you if your insurance company reprocesses and pays the claim in question.

- A copy of your insurance card may be required at each visit to our office. It is your responsibility to ensure that all insurance information provided at your visit is current and correct. Under the new Healthcare Initiative, it may be necessary for you to provide month-to-month proof of eligibility under the Colorado Health Exchange programs. Failure to disclose accurate information may result in a bill for services rendered.

- Any personal check returned to the office for insufficient funds will have a $20.00 service fee added to the account in addition to the original amount of the check. All subsequent visit copays or balances will need to be paid with cash, credit/debit cards or certified funds.

I have read, understand and agree to the aforementioned financial policies for Avista Women's Care. _____ (Guarantor Initials)

_____ _____

Patient/Guarantor Signature Patient/Guarantor Printed Name

_____

Today's Date

IV. Questions, Concerns, and Changes to this Notice

If you have any questions or concerns about any of the information in this Notice of Privacy Practices, please contact our Practice Manager at 303 439 8910.

If you believe your privacy rights have been violated, you may file a complaint with our Practice Manager, the iPN Security Officer (303 269-2054), or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. We will not retaliate against you for filing a complaint.

We may change our Notice of Privacy Practices in the future. Such changes will apply to your health information that we created or received before the effective date of the change. We will notify you of any changes to our Notice of Privacy Practices by distributing the changed Notice during future office visits and by posting it in our reception areas.

Avista Women's Care
90 Health Park Dr
Suite 290
Louisville, CO 80027
303 439 8910

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES MUST BE MADE IN WRITING AND A COPY KEPT IN YOUR MEDICAL RECORD.

PLEASE SIGN AND RETURN THE ATTACHED SIGNATURE PAGE.

A member practice of the
Integrated Physician Network

integrated Physician Network accountability value sustainability

Avista Women's Care

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE LEGALLY USED AND DISCLOSED IN THE PROCESS OF PROVIDING YOU THE BEST POSSIBLE CARE. IT INCLUDES YOUR RIGHTS REGARDING PERSONAL HEALTH INFORMATION UNDER FEDERAL LAW. PLEASE REVIEW IT CAREFULLY