

**Colorado Complete Health for Women  
Patient Information Form**

Today's Date: \_\_\_\_\_ Age at **TODAY'S** Visit \_\_\_\_\_ Years  
Patient's Name (First): \_\_\_\_\_ (Last): \_\_\_\_\_ (Middle): \_\_\_\_\_  
Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
SSN #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex (circle): F M  
Marital Status (circle): Married Single Divorced Widowed Other  
Employment Status (circle): Employed Self-Employed Unemployed Retired  
Full Time Student Part time Student  
Employer Name: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Who referred you to our Practice? \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

**Spouse/Partner Information**

Name (First): \_\_\_\_\_ (Last) \_\_\_\_\_ (Middle) \_\_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex (circle): F M Occupation: \_\_\_\_\_  
Emergency Contact (not at same address): \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

**Responsible Party and Primary Insurance Information**

Responsible Party Name (First): \_\_\_\_\_ (Last) \_\_\_\_\_ (MI) \_\_\_\_\_  
Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
SSN #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex (circle): F M  
Employer Name: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Insurance Name: \_\_\_\_\_  
Customer Service Phone: (\_\_\_\_) \_\_\_\_\_  
Subscriber ID: \_\_\_\_\_ Group ID: \_\_\_\_\_ Copay \$ \_\_\_\_\_  
Effective Date \_\_\_\_\_ Termination Date: \_\_\_\_\_  
Billing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Secondary Insurance Information**

Insurance Name: \_\_\_\_\_ Customer Service Phone: (\_\_\_\_) \_\_\_\_\_  
Subscriber ID: \_\_\_\_\_ Group ID: \_\_\_\_\_ Copay \$ \_\_\_\_\_  
Effective Date \_\_\_\_\_ Termination Date: \_\_\_\_\_  
Billing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Please share your EMAIL address** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## How Can We Reach You?

Your provider will at times need to contact you. By filling out the information below we will be better able to serve you.

NAME (PLEASE PRINT) \_\_\_\_\_  
HOME PHONE NUMBER \_\_\_\_\_  
WORK PHONE NUMBER \_\_\_\_\_  
CELLULAR PHONE NUMBER \_\_\_\_\_

### HealthOne Clinic Services PHONE MESSAGE CONSENT

In effort to protect your privacy, we have developed a policy on leaving medical care messages:

- We will **NOT** leave messages with anyone except the patient or legal guardian.
- We will **NOT** leave any confidential information on an answering machine.
- We will **NOT** leave any messages on a voicemail.

#### ***UNLESS***

WE HAVE YOUR WRITTEN PERMISSION TO DO SO.

Please read below and consider carefully whom you authorize to have access to protected information regarding your care.

I, \_\_\_\_\_ give HealthONE my permission to speak with and/or leave phone messages regarding my medical care and/or billing with the following. I fully understand that this consent will remain valid until revoked in writing.

My Home answering machine: # \_\_\_\_\_ Initials \_\_\_\_\_

My Cell answering machine: # \_\_\_\_\_ Initials \_\_\_\_\_

My Office/Work voice mail: # \_\_\_\_\_ Initials \_\_\_\_\_

My Spouse/Guardian: # \_\_\_\_\_ Initials \_\_\_\_\_

Other: # \_\_\_\_\_ Initials \_\_\_\_\_

*If other:* Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Colorado Complete Health for Women  
HealthOne Clinic Services  
Authorization to Disclose Personal Health Information

I \_\_\_\_\_ authorize the disclosure of my personal health information to the following person/people.

\_\_\_\_\_  
Name Relationship \_\_\_\_\_

\_\_\_\_\_  
Name Relationship \_\_\_\_\_

\_\_\_\_\_  
Name Relationship \_\_\_\_\_

\_\_\_\_\_  
Name Relationship \_\_\_\_\_

\_\_\_\_\_  
Name Relationship \_\_\_\_\_

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents

\_\_\_\_\_  
**Signature** **Date** \_\_\_\_\_

Colorado Complete Health for Women  
HealthOne Clinic Services

**Financial Policy:**

In order to reduce confusion and misunderstanding between our patients and the practice we have adopted the following financial policy. If you have any questions please discuss them with our billing staff. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

Unless other arrangements have been made in advance by yourself or your health coverage carrier, full payment for office services are due at the time of service. For you convenience we will accept VISA, MasterCard, Discover, and American Express, as well as cash, check or money order.

**About Health Insurance:**

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer we will refund any overpayment to you.

**About Participating Health Plans:**

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-payment **at the time of service**.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of statement from our office.

For all service rendered to minor patients we will look to the adult accompanying the patient and parent or guardian with custody for payment.

It is your responsibility to verify that this office participated with your insurance. If we do not participate with your insurance, you will likely be responsible for all charges out of pocket.

**By signing below, I acknowledge that I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed name if signed on behalf of patient**

\_\_\_\_\_  
**Relationship to Patient**

Colorado Complete Health for Women  
HealthOne Clinic Services  
HPV & Pap Smears

In the past ten years our understanding of abnormal tissue growth on the cervix cause by HPV (Human Papillomavirus) has grown exponentially. We now realize that significant cervical abnormalities and cancers of the cervix are caused by the High Risk strains of HPV. We are also aware that 50-75% of women will clear/suppress an HPV infection within 18 months and that it takes several years for an initial HPV infection to progress into significant precancerous or cancerous abnormalities. Based on these new scientific understandings our professional organizations have made the following recommendations:

1. **Adolescents (age 20 and under)** who become sexually active should be seen by an OB-GYN or other practitioner for a pelvic exam and screening for sexually transmitted diseases such as Gonorrhea and Chlamydia. However, a pap smear should not be performed until 3 years after initiation of sexual contact – since the vast majority of High Risk HPV infections will be cleared/suppressed spontaneously by the woman.
2. For women **age 21-29**, an HPV test is performed if the Pap test reveals cells that are “atypical”
3. For **women 30 and over**, the combined use of the Pap smear and an HPV test can markedly increase the sensitivity of the test looking for significant precancerous cervical changes. A Pap test alone can miss 20-30% of precancerous cervical changes whereas a combined Pap/HPV test will miss only 1 in 1000 significant precancerous changes. If a woman has a normal Pap test and a normal HPV test, she will still need to be seen yearly for a pelvic and breast exam, but may not need a Pap test for 3 years. If a woman tests persistently positive for High Risk HPV (even with normal cervical cells), she needs to be evaluated just as if the cells had been abnormal – looking at the cells with a special microscope (colposcopy).

Like so many things in medicine, our new understandings must initiate new protocols for their diagnosis and management. **Regardless of your pap and/or HPV status, women must be seen annually (pelvic exam, breast exam, etc).**

While the HPV test is covered by most insurance plans, you may receive a bill due to the following: 1. You have not yet met your annual deductible, 2. Your insurance plan has a co-share (i.e. Plan pays 80%, Patient pays 20%), 3. You have a Lab deductible, 4. Your employer has decided to “carve out” or not pay for specific screening tests.

Please call the following number to determine your specific payment responsibility:

1-866-895-1HPV (1-866-895-1478)

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents

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**Patient (or Responsible Party) Signature      Date**