



Welcome to The Women's Health Group! We understand you have many options for healthcare providers. We are happy that you chose us! Visiting a new doctor can be an unnerving experience. We are here for you and hope to make your visit as pleasant as possible.

In order to get to know you better and eliminate some of your waiting time, we are enclosing your new patient paperwork in this packet. **Please complete all the forms and bring them with you to your appointment. Please have your current insurance card and a photo I.D. with you (a driver's license or state-issued identification card will be sufficient).** The enclosed checklist should help you remember everything for your appointment.

It is our policy to collect all co-payments, co-insurance, and deductibles at the time of service. If you are unable to make such payments at the time of your appointment, please call our billing department at 303-280-2229, option 3 to make financial arrangements prior to your visit. We now offer Simple Solutions, an easy way to make automatic payments on your account through your credit card. You will find the paperwork for Simple Solutions enrollment in this packet.

Our physicians make every effort to maintain a time-efficient schedule however occasionally a patient will have more questions than expected and will require extra time. And you know babies- they come when they are ready, so your physician may get called out to a delivery. If the doctor is called away during your appointment time, we will do everything we can to accommodate your schedule. You may be able to see another physician if time permits. Please understand this is a people-business and schedule changes and interruptions are sometimes unavoidable.

The patient portal, accessed through our website, www.whg-pc.com, has options to request an appointment, and once you are established with us, request prescription refills and pay your bill. Our website also offers educational material, pictures and biographies of our physicians, as well as many useful links. You can also find us on Facebook at www.facebook.com/thewomenshealthgroup. We have Facebook discussion topics planned for the upcoming months, so tune in! You can also stay informed about product recalls and office news through our Facebook page.

If you ever have a concern, a question, or a compliment, please feel free to contact our office. You can call us at our main phone number, 303-280-2229 or send an email to: info@whg-pc.com. Our Patient Experience Coordinator will research your request and respond to you promptly.

Thank you for choosing The Women's Health Group! We look forward to seeing you soon!

Sincerely,

The Physicians and Staff at The Women's Health Group

THE WOMEN'S HEALTH GROUP, P.C.
PATIENT REGISTRATION

PATIENT INFORMATION

Legal Name _____

Street Address _____ Last _____ First _____ Middle Initial _____ Apt/Unit # _____

City _____ State _____ Zip Code _____

Birth Date _____ Age _____ SS # _____ Marital Status // S // M // D // Other _____

Race _____ Ethnicity - Hispanic // Non-Hispanic // Decline _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Email Address _____

Preferred Pharmacy _____ Address _____

Spouse/Responsible Party: Name _____ SS# _____

Work Phone _____ Employer/Occupation _____

INSURANCE INFORMATION

Primary Insurance _____ Type (HMO, PPO, etc) _____

Insured's Name _____ Relationship to Insured _____

ID # _____ Group # _____ Insured's Birth Date _____

Claims Address _____

Membership Services Phone _____ **Effective Date** _____

Secondary Insurance _____ Type (HMO, PPO, etc) _____

Insured's Name _____ Relationship to Insured _____

ID # _____ Group # _____ Insured's Birth Date _____

Claims Address _____

Membership Services Phone _____ **Effective Date** _____

ADDITIONAL INFORMATION

Emergency Contact _____ Relationship to patient _____

Home Phone _____ Work phone _____

Family Physician _____ Phone number _____

Whom may we thank for referring you? _____

MEDICAL INFORMATION AUTHORIZATION: I authorize release of any medical information necessary to process my claims.

Signed _____ Date _____

ASSIGNMENT OF BENEFITS AND AGREEMENT FOR PAYMENT: I authorize medical benefits to the named provider. I understand that I am financially responsible for charges not covered by this authorization. I agree to pay all noncovered fees incurred within 30 days or my account may incur interest at the rate of 18% ANNUAL PERCENTAGE RATE. I further agree to pay all costs including actual attorney fees incurred for collection of my account.

Signed _____ Date _____

THE WOMENS HEALTH GROUP, PC

Patient Questionnaire

Patient Name _____ **DOB** _____

Reason for visit _____ **DATE** _____

Last Annual exam: Date _____

Last Colonoscopy: Date _____ Result _____

Last Diabetes Screen: Date _____ Result _____

Last Cholesterol Screen: Date _____ Result _____

Last Mammogram: Date _____ Result _____

Last Osteoporosis Screen: Date _____ Result _____

Last Pap Screen: Date _____ Result _____

Last Thyroid Screen: Date _____ Result _____

PAST GYNECOLOGICAL HISTORY

- | | | |
|--|--|--|
| <input type="checkbox"/> Birth control
Type _____ | <input type="checkbox"/> Ectopic Pregnancy | <input type="checkbox"/> No Periods |
| <input type="checkbox"/> Cervical Dysplasia | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Abnormal Bleeding |
| <input type="checkbox"/> Fluid in fallopian tubes | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Painful Periods |
| <input type="checkbox"/> Vaginal Dysplasia | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pelvic Pain |
| <input type="checkbox"/> Vulvar Dysplasia | <input type="checkbox"/> Infertility | <input type="checkbox"/> Pelvic Infection |
| Other _____ | <input type="checkbox"/> Menopause | <input type="checkbox"/> Pelvic Mass |
| | | <input type="checkbox"/> Pelvic Prolapse |

PAST MEDICAL HISTORY

- | | | |
|---|---|--|
| <input type="checkbox"/> Abnormal Mammogram | <input type="checkbox"/> Elevated Prolactin | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Breast Cyst | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Blood Transfusion in past |
| <input type="checkbox"/> Fibrocystic Breast Disease | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Coagulation Disorder |
| <input type="checkbox"/> Breast Discharge | <input type="checkbox"/> Metabolic Syndrome | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Breast Mass | <input type="checkbox"/> Obesity | <input type="checkbox"/> Blood clot in leg/lung |
| <input type="checkbox"/> Breast Pain | <input type="checkbox"/> Polycystic Ovarian
Syndrome | <input type="checkbox"/> Von Willebrand's Disease |
| <input type="checkbox"/> Cancer
Type _____ | <input type="checkbox"/> Lupus | <input type="checkbox"/> Chronic Back Pain |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anal Fissures | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Constipation | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Reflux Disease/Heartburn | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Diabetes Type _____ | <input type="checkbox"/> Irritable Bowel Syndrome | |

- | | | |
|---|---|---|
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Interstitial Cystitis |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bladder urgency |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> COPD/Obstructive
Bronchitis | <input type="checkbox"/> Protein/Blood in Urine |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Kidney/Bladder Infections |
| <input type="checkbox"/> Depression | | <input type="checkbox"/> Incontinence/Loss of urine |
| <input type="checkbox"/> Other _____ | | <input type="checkbox"/> Kidney Stones |

PAST GYNECOLOGICAL SURGERY

- | | | |
|--|--|----------------------|
| <input type="checkbox"/> Cesarean Section | Number _____ | Reason _____ |
| <input type="checkbox"/> Ectopic Pregnancy | Side _____ | Treatment _____ |
| <input type="checkbox"/> Hysteroscopy | Date _____ | Diagnosis _____ |
| <input type="checkbox"/> Hysterectomy | Date _____ | Diagnosis/Type _____ |
| | <input type="checkbox"/> Ovaries Removed | Reason _____ |
| <input type="checkbox"/> Laparoscopy | Date _____ | Diagnosis _____ |
| <input type="checkbox"/> Prolapse/Incontinence | Date _____ | Type _____ |
| <input type="checkbox"/> Sterilization | Date _____ | Type _____ |

PAST SURGERIES

- | | | |
|--|---|---|
| <input type="checkbox"/> Abdominal Surgery | <input type="checkbox"/> Hand Surgery | <input type="checkbox"/> Chest Surgery |
| <input type="checkbox"/> Ankle Surgery | <input type="checkbox"/> Hemorrhoid Surgery | <input type="checkbox"/> Thyroid Removed |
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> TMJ Surgery |
| <input type="checkbox"/> Bariatric - LapBand | <input type="checkbox"/> Knee Surgery | <input type="checkbox"/> Tonsils/Adenoids |
| <input type="checkbox"/> Bariatric – Roux-en-Y | <input type="checkbox"/> Lasik | <input type="checkbox"/> Hip Replacement |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Spine Surgery | <input type="checkbox"/> Knee Replacement |
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Neck Surgery | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Plastic Surgery | _____ |
| <input type="checkbox"/> Gall Bladder Removed | <input type="checkbox"/> Shoulder Surgery | |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Sinus Surgery | |
| <input type="checkbox"/> Brain Surgery | <input type="checkbox"/> Skin Biopsy | |
| <input type="checkbox"/> Bladder Scope | <input type="checkbox"/> Skin Tag Removal | |
| <input type="checkbox"/> Foot Surgery | <input type="checkbox"/> Spleen Removed | |

MEDICATIONS

TYPE	DOSE	DATE STARTED

ALLERGIES _____

FAMILY HISTORY

- | | | |
|--|--|--|
| <input type="checkbox"/> Breast Cancer _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Sickle Cell Disease/Trait |
| <input type="checkbox"/> Colon Cancer _____ | <input type="checkbox"/> Thyroid Disease _____ | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Kidney Cancer _____ | <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper | <input type="checkbox"/> Blood Clots/Coagulation D/O |
| <input type="checkbox"/> Ovarian Cancer _____ | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Von Willebrand's Disease |
| <input type="checkbox"/> Prostate Cancer _____ | <input type="checkbox"/> Problems w. Anesthesia | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Uterine Cancer _____ | | _____ |

GENETIC DISORDERS

LIST ANY GENETIC DISORDERS OR SYNDROMES COMMON IN YOUR FAMILY

PAST OBSTETRICAL HISTORY

How many times have you been pregnant? _____ How many deliveries have you had? _____ How many miscarriages? _____ Abortions? _____ Tubal pregnancy? _____
How many living children do you have? _____ How many, if any, were premature? _____
Have you had any c/sections? If yes, how many? _____

SOCIAL HISTORY

SUBSTANCE USE

<input type="checkbox"/> Tobacco	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Amount _____	Age Start _____	Age Stop _____
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Amount _____	Age Start _____	Age Stop _____
<input type="checkbox"/> Caffeine	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Amount _____	Age Start _____	Age Stop _____
<input type="checkbox"/> Street Drugs					
Type _____	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Amount _____	Age Start _____	Age Stop _____
_____	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Amount _____	Age Start _____	Age Stop _____
<input type="checkbox"/> Narcotics	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Amount _____	Age Start _____	Age Stop _____

EDUCATION

<input type="checkbox"/> High School	<input type="checkbox"/> College, 2 year
<input type="checkbox"/> Did not complete High School	<input type="checkbox"/> College, 4 year
<input type="checkbox"/> GED	<input type="checkbox"/> Graduate Studies/Degree
<input type="checkbox"/> Graduated High School	<input type="checkbox"/> Post Graduate Studies/Degree

OCCUPATION

EXERCISE

None Active, but no formal exercise
 Less than once a week 2-4 times/week greater than 4 times/week

DOMESTIC VIOLENCE History of... Current
 Emotional/Verbal Physical
 Parent Spouse

MARITAL STATUS

Dating Divorced Engaged Married Non-Dating Single Widowed

Partners Name _____

THE WOMEN'S HEALTH GROUP, PC
SYMPTOM REVIEW

NAME _____ DATE _____

PLEASE NOTE ANY SYMPTOMS YOU HAVE RECENTLY HAD THAT YOU FEEL ARE ASSOCIATED WITH YOUR VISIT TODAY. IT IS NORMAL NOT TO HAVE MOST OF THESE SYMPTOMS.

- | | | | |
|-------------------------|--|---|---|
| CONSTITUTIONAL | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Weight Gain |
| | <input type="checkbox"/> Other _____ | | |
| EYES | <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Other _____ | |
| HEAD/NECK | <input type="checkbox"/> Sinus Congestion | <input type="checkbox"/> Dentures | <input type="checkbox"/> Decreased Hearing |
| | <input type="checkbox"/> Other _____ | | |
| BREAST | <input type="checkbox"/> Lumps | <input type="checkbox"/> Tenderness | <input type="checkbox"/> Nipple Discharge |
| | <input type="checkbox"/> Other _____ | | |
| CARDIOVASCULAR | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Fainting |
| | <input type="checkbox"/> Other _____ | | |
| RESPIRATORY | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Cough |
| | <input type="checkbox"/> Other _____ | | |
| GASTROINTESTINAL | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| | <input type="checkbox"/> Constipation | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Other _____ |
| GENITOURINARY | <input type="checkbox"/> Urgency | <input type="checkbox"/> Frequency | <input type="checkbox"/> Dysuria |
| | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Other _____ |
| SKIN | <input type="checkbox"/> Rash | <input type="checkbox"/> Changes in Moles | <input type="checkbox"/> Changes in Lesions |
| | <input type="checkbox"/> Other _____ | | |
| NEUROLOGICAL | <input type="checkbox"/> Muscular Weakness | <input type="checkbox"/> Incoordination | <input type="checkbox"/> Tingling/Numbness |
| | <input type="checkbox"/> Other _____ | | |
| MUSCULOSKELETAL | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Muscle Pain | Other _____ |
| ENDOCRINE | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Constant Drinking | <input type="checkbox"/> Cold Intolerance |
| | <input type="checkbox"/> Heat Intolerance | <input type="checkbox"/> Other _____ | |
| PSYCHIATRIC | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Difficult Sleeping |
| | <input type="checkbox"/> Other _____ | | |
| HEME-LYMPH | <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Lymph Node Pain |
| ALLERGIC-IMMUNE | <input type="checkbox"/> Sinus Symptoms | <input type="checkbox"/> Frequent Illness | <input type="checkbox"/> Other _____ |

MENSTRUAL HISTORY

Menses began _____ y/o Cycle Interval _____ days Duration _____ days

light medium heavy Last period _____

Birth Control Method _____ Home Pregnancy Test Positive Negative

Peri-menopause Menopause Age began _____



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303-665-0121

6363 West 120th Avenue, Suite 300
Broomfield, CO 80020
303-460-7116
303-460-8204

www.whg-pc.com

OFFICE FINANCIAL POLICY

Thank you for choosing The Women's Health Group for your health needs. Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance about our office policies allows for a good flow of communication and enables us to achieve our goal.

Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

Insurance Plans

- It is your responsibility to keep The Women's Health Group up to date with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment for the visit.**
- We must emphasize that, as your medical provider, our relationship is with you, not your insurance company. As a courtesy, we file your medical claim to your insurance at no charge.
- According to your insurance plan, you are responsible for any and all copayments, deductibles, and co-insurances. We do ask that you pay all co-pays, deductibles, and non-covered charges the day of your service.
- WHG calls and verifies benefits for surgical procedures and obstetrics. However, it is still the patient's responsibility to know their benefits and we encourage you to contact your insurance as well.
- WHG will keep a confidential credit/debit card on file with us. This information is stored in a secure system that complies with Payment Card Industry Data Security Standard. You will have the option to have balances automatically run (for your convenience) or be contacted by the Billing Department prior to running your card for unpaid balances.
- Please always feel free to contact our Billing Department with any concerns, questions, or information regarding your account.

Self-Pay

If you do not have insurance, self-pay patients will be expected to pay at the time of service. Surgical procedures and obstetrics will be discussed with the patient for payment prior to the procedure being performed.

OFFICE POLICIES

After-Hour Emergencies

If you should experience a life-threatening emergency, please call 911 or go to the closest emergency room.

If you have other after-hours emergencies, you may contact the physician on-call by call our main number. This service is for emergency or potential emergency care only. Please call during regular business hours for non-urgent questions or concerns.

After-Hours Narcotics

There will be no refills of any narcotic after hours or on weekends. Please call during our regular business hours.

Late Appointment Arrival

We ask that all patients arrive at the designated time. If you do arrive late for your appointment, we may need to see other patients before we can see you. In addition, if you are more than 15 minutes late, you may be asked to reschedule.

Cancellations and No-Shows

As a courtesy to other patients, we request that you notify WHG as soon as possible if you need to change your appointment. This allows us to offer that appointment time to another patient.

We understand that sometimes unforeseen circumstances may arise on the day of your appointment. But we ask you give notice as soon as possible (24 hours if possible) if you will not be able to make your appointment.

If you have missed your appointments 3 times and have not cancelled or reschedules, you may be dismissed from our practice.

The Women's Health Group strives to offer you the very best medical care; therefore, we have implemented these policies to continue providing premium care to all of our patients.

I have read and understand the Financial/Office Policies:

Patient/Responsibility Party Signature

Date

Print Patient Name

Date of Birth

**The Women's
HEALTH GROUP, P.C.**



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The Women's Health Group offers you quality medical care and has implemented these policies to be able to continue providing the highest level of care for all of our patients.

I have read, understand, and agree to the Financial/Office Policies:

Patient/Responsibility Party Signature

Date

Print Patient Name

Date of Birth

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SIMPLE SOLUTIONS

I, _____ authorize The Women's Health Group, P.C. to charge my credit card for payments due including my co-pays, co-insurance, deductible, non-covered charges *and* charges billed but not paid by my insurance company within 60 days. I understand the process is:

- WHG will bill my insurance and wait for insurance to pay
- WHG will then send me 2 statements over a 60 day period (I have the option to pay however I want – check, credit card, etc.)
- If no payment is received in 60 days, WHG will attempt to contact me to arrange for payment.
- If we receive no response after mailed statements, phone calls, and/or emails, the "Patient Responsibility Amount" shown on my Explanation of Benefits (EOB), will be transferred to my credit card as listed below.

Options:

- Process my credit card automatically.
- I prefer a courtesy call (phone) _____ or (email) _____ to alert me to the processing date of the credit card.

I understand that The Women's Health Group, P.C. will submit my claims to the insurance company as a courtesy, but timely payment to my account is my responsibility.

I assign my insurance benefits to The Women's Health Group, P.C. I authorize The Women's Health Group, P.C. to maintain my credit card information on file for *SIMPLE SOLUTIONS* purposes only

 Cardholder signature

 Date

This form will be renewed annually and upon expiration of credit card

Patient Name _____	Phone: _____
Cardholder Name (Please Print) _____	
Cardholder Address (Please Print) _____	
City, State, Zip (Please Print) _____	
Circle one: Visa MasterCard Discover HSA (Health Savings Account)	
Credit Card Number _____	Exp: _____ Security Code _____

Office use only:				
Account Number _____	Date Entered _____	Approved _____	Declined _____	Initials _____

APPOINTMENT CHECKLIST

- Forms (filled out completely)
- Insurance card
- Photo I.D. (Driver's license or other state issued identification card)
- Co-payment (cash, check, credit card)
- Simple Solutions paperwork

QUESTIONS I WANT TO REMEMBER TO ASK THE DOCTOR:



PATIENT HIPAA QUESTIONNAIRE AND ACKNOWLEDGEMENT

I have received a copy of the Women's Health Group, P.C.'s Notice of Privacy Practices.

- I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

Name: _____ Phone: _____

Name: _____ Phone: _____

- II. Please list the family members or significant others, if any whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name: _____ Phone: _____

Name: _____ Phone: _____

- III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

- IV. Please print the telephone number where you want to receive calls about your appointments, lab results, or other health care information if other than your home phone number:

() _____

- I am fully aware that a cell phone is not a secure and private line.
- I am fully aware my health information can be transmitted by facsimile (fax), mail, email, or the internet.

- V. Can confidential messages (i.e., appointment reminders) be left on your home answering machine or voicemail?

YES _____ NO _____

PATIENT NAME _____

PATIENT SIGNATURE _____

DATE _____