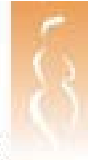
The Women's HEALTH GROUP, P.C. 

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303-460-8204

www.whg-pc.com

Congratulations! The Women's Health Group is pleased to be a part of this exciting time in your life. In order to provide you with the best care possible, we ask you to carefully read and follow through with the following instructions. Please ask if you do not understand any of the items in your information packet!

1. If you experience any changes in your insurance coverage or financial situation during your pregnancy, please notify us immediately and provide us with a copy of your insurance card as soon as possible.
   a. Our Thornton providers deliver at North Suburban Medical Center
   b. Our Lafayette providers deliver at Exempla Good Samaritan Medical Center.
   c. Which facility you will deliver at depends on which provider you see in Broomfield.
   d. Please check with your insurance to see what coverage you have at the facility you prefer.

2. To assist you in budgeting for your out-of-pocket expenses, deductibles, or cash payment for your obstetric care and delivery, our Patient Financial Counselor will meet with you to discuss a payment plan and your financial obligations.

3. As a courtesy, two months prior to your estimated due date, we will contact your insurance company to pre-authorize your delivery.

4. If you should be hospitalized prior to delivery, it is your responsibility to notify our office and your insurance company. Please make a note of the date and time you call and to whom you spoke.

5. In case of an emergency, the doctor on call can be contacted by calling your office: Thornton 303-280-2229 (BABY) or Lafayette 303-665-6016. **If it is not an emergency, please call during routine office hours: Monday through Friday, 8:30AM- 4:30PM.** We will return your call as soon as possible. If you set up a block on your phone, please unblock it by dialing *82 or we may not be able to return your call.

We suggest you review these instructions with your partner, parent, or friend who is participating in your healthcare and pregnancy.

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____
Last First Middle Initial

Street Address____ 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

[ ]Birth control
Type_________
[ ]Cervical Dysplasia
[ ]Fluid in fallopian tubes
[ ]Vaginal Dysplasia
[ ]Vulvar Dysplasia
Other___________________

[ ]Ectopic Pregnancy
[ ]Endometriosis
[ ]Fibroids
[ ]Herpes
[ ]Infertility
[ ]Menopause

[ ]No Periods
[ ]Abnormal Bleeding
[ ]Painful Periods
[ ]Pelvic Pain
[ ]Pelvic Infection
[ ]Pelvic Mass
[ ]Pelvic Prolapse

PAST MEDICAL HISTORY

[ ]Abnormal Mammogram
[ ]Breast Cyst
[ ]Fibrocystic Breast Disease
[ ]Breast Discharge
[ ]Breast Mass
[ ]Breast Pain

[ ]Elevated Prolactin
[ ]Hyperthyroid
[ ]Hypothyroid
[ ]Metabolic Syndrome
[ ]Obesity
[ ]Polycystic Ovarian Syndrome

[ ]Anemia
[ ]Blood Transfusion in past
[ ]Coagulation Disorder
[ ]Varicose Veins
[ ]Blood clot in leg/lung
[ ]Von Willebrand's Disease

[ ]Cancer
Type____________
[ ]Lupus
[ ]Chronic Back Pain

[ ]High Blood Pressure
[ ]High Cholesterol
[ ]Heart Palpitations
[ ]Mitral Valve Prolapse
[ ]Diabetes Type__________

[ ]Anal Fissures
[ ]Constipation
[ ]Reflux Disease/Heartburn
[ ]Hemorrhoids
[ ]Irritable Bowel Syndrome

[ ]Fibromyalgia
[ ]Osteopenia
[ ]Osteoporosis
[ ]Headaches/Migraines

[ ]Seizure Disorder
[ ]Alcohol/Drug Abuse
[ ]Anxiety Disorder
[ ]Bipolar Disorder
[ ]Depression
[ ]Other_________________ ________________________

[ ]Seasonal Allergies
[ ]Asthma
[ ]COPD/Obstructive Bronchitis
[ ]Chronic Sinusitis

[ ]Interstitial Cystitis
[ ]Bladder urgency
[ ]Protein/Blood in Urine
[ ]Kidney/Bladder Infections
[ ]Incontinence/Loss of urine
[ ]Kidney Stones

PAST GYNECOLOGICAL SURGERY

[ ]Cesarean Section Number___________ Reason___________________________
[ ]Ectopic Pregnancy Side______________ Treatment_________________________
[ ]Hysteroscopy Date_____________ Diagnosis__________________________
[ ]Hysterectomy Date_____________ Diagnosis/Type______________________
[ ]Ovaries Removed Reason___________________________
[ ]Laparoscopy Date_____________ Diagnosis__________________________
[ ]Prolapse/Incontinence Date_____________ Type______________________________
[ ]Sterilization Date_____________ Type______________________________

PAST SURGERIES

[ ]Abdominal Surgery
[ ]Ankle Surgery
[ ]Appendix
[ ]Bariatric - LapBand
[ ]Bariatric – Roux-en-Y
[ ]Bronchoscopy
[ ]Cataract Surgery

[ ]Gall Bladder Removed
[ ]Colonoscopy
[ ]Brain Surgery
[ ]Bladder Scope
[ ]Foot Surgery

[ ]Hand Surgery
[ ]Hemorrhoid Surgery
[ ]Hernia Repair
[ ]Knee Surgery
[ ]Lasik
[ ]Spine Surgery
[ ]Neck Surgery
[ ]Plastic Surgery

[ ]Shoulder Surgery
[ ]Sinus Surgery
[ ]Skin Biopsy
[ ]Skin Tag Removal
[ ]Spleen Removed

[ ]Chest Surgery
[ ]Thyroid Removed
[ ]TMJ Surgery
[ ]Tonsils/Adenoids
[ ]Hip Replacement
[ ]Knee Replacement
[ ]Other___________________

____

MEDICATIONS

TYPE_________________________DOSE__________________________DATE STARTED___________

____
____
____

ALLERGIES ____

FAMILY HISTORY

[ ]Breast Cancer___________
[ ]Colon Cancer____________
[ ]Kidney Cancer___________

[ ]Ovarian Cancer__________
[ ]Prostate Cancer__________

[ ]Uterine Cancer__________

[ ]Heart Disease___________
[ ]Thyroid Disease__________
[ ]Hypo [ ]Hyper

[ ]Osteoporosis
[ ]Problems w. Anesthesia

[ ]Sickle Cell Disease/Trait
[ ]Lupus
[ ]Blood Clots/Coagulation D/O
[ ]Von Willebrand’s Disease
[ ]Other____________________

____

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

[ ]Tobacco	[ ]Current	[ ]Past	Amount______	Age Start______	Age Stop______
[ ]Alcohol	[ ]Current	[ ]Past	Amount______	Age Start______	Age Stop______
[ ]Caffeine	[ ]Current	[ ]Past	Amount______	Age Start______	Age Stop______
[ ]Street Drugs					
Type__________	[ ]Current	[ ]Past	Amount______	Age Start______	Age Stop______
__________	[ ]Current	[ ]Past	Amount______	Age Start______	Age Stop______
[ ]Narcotics	[ ]Current	[ ]Past	Amount______	Age Start______	Age Stop______

EDUCATION
[ ]High School
[ ] Did not complete High School
[ ]GED
[ ]Graduated High School
[ ]College, 2 year
[ ]College, 4 year
[ ]Graduate Studies/Degree
[ ]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	[ ] Fatigue	[ ]Weight Loss	[ ]Weight Gain
	[ ]Other____________		
EYES	[ ]Glasses/Contacts	[ ]Other____________	
HEAD/NECK	[ ]Sinus Congestion	[ ]Dentures	[ ]Decreased Hearing
	[ ]Other____________		
BREAST	[ ]Lumps	[ ]Tenderness	[ ]Nipple Discharge
	[ ]Other____________		
CARDIOVASCULAR	[ ]Chest Pain	[ ]Irregular Heart Beat	[ ]Fainting
	[ ]Other____________		
RESPIRATORY	[ ]Shortness of Breath	[ ]Wheezing	[ ]Cough
	[ ]Other____________		
GASTROINTESTINAL	[ ]Nausea	[ ]Vomiting	[ ]Diarrhea
	[ ]Constipation	[ ]Blood in Stools	[ ]Other____________
GENITOURINARY	[ ]Urgency	[ ]Frequency	[ ] Dysuria
	[ ]Incontinence	[ ]Decreased Libido	[ ]Other____________
SKIN	[ ]Rash	[ ]Changes in Moles	[ ]Changes in Lesions
	[ ]Other____________		
NEUROLOGICAL	[ ]Muscular Weakness	[ ]Incoordination	[ ]Tingling/Numbness
	[ ]Other____________		
MUSCULOSKELETAL	[ ]Joint Pain	[ ]Muscle Pain	Other______________
ENDOCRINE	[ ]Frequent Urination	[ ]Constant Drinking	[ ]Cold Intolerance
	[ ]Heat Intolerance	[ ]Other____________	
PSYCHIATRIC	[ ]Anxiety	[ ]Depression	[ ]Difficult Sleeping
	[ ]Other____________		
HEME-LYMPH	[ ]Easy Bleeding	[ ]Easy Bruising	[ ]Lymph Node Pain
ALLERGIC-IMMUNE	[ ]Sinus Symptoms	[ ]Frequent Illness	[ ]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___________

THE WOMENS HEALTH GROUP, PC
New OB Patient Questionnaire

Name: ____

Birth date: ____________________ Age: _________________________

When was your last menstrual period (1st day)? ____________________________________

Are your cycles [ ] Regular [ ] Irregular

Were you on birth control when you became pregnant? [ ] Yes [ ] No

How did you find out you were pregnant?

[ ] Home pregnancy test [ ] Missed period [ ] Doctor Visit

Was your last period normal? [ ] Yes [ ] No

Did it occur at the expected time? [ ] Yes [ ] No

What pregnancy symptoms are you having? ____________________________________

Did you have any of the following medical problems in a previous pregnancy? (Mark all that apply):

	Yes	No
Preeclampsia	[ ]	[ ]
Gestational Diabetes	[ ]	[ ]
Preterm labor	[ ]	[ ]
High blood pressure	[ ]	[ ]
Blood clot	[ ]	[ ]

Other (please list) ____

Please list anything you may have taken or used since your last period, including prescription or over the counter drugs, vitamins, supplements, herbals medications, or recreational drugs (e.g. alcohol, speed or cocaine):____

____

______

1. Will you be 35 or older when you deliver? [ ] Yes [ ] No

Do you, the baby's father, or any family members have any of the following?

	Yes	No	If yes, who?
2. Thalassemia	[ ]	[ ]	________________________
3. Neural Tube defect	[ ]	[ ]	________________________
4. Congenital heart disease	[ ]	[ ]	________________________
5. Down syndrome	[ ]	[ ]	________________________
6. Tay Sachs	[ ]	[ ]	________________________
7. Canavan's Disease	[ ]	[ ]	________________________
8. Sickle cell disease or trait	[ ]	[ ]	________________________
9. Hemophilia	[ ]	[ ]	________________________
10. Muscular dystrophy	[ ]	[ ]	________________________
11. Cystic fibrosis	[ ]	[ ]	________________________
12. Huntington's chorea	[ ]	[ ]	________________________
13. Mental retardation / autism	[ ]	[ ]	________________________
14. Any other genetic disorders	[ ]	[ ]	________________________
15. Birth defect not listed above	[ ]	[ ]	________________________
16. Recurrent pregnancy losses	[ ]	[ ]	________________________
17. Jewish or Black ancestry	[ ]	[ ]	________________________

1. Do you live with someone with tuberculosis or have you been exposed to tuberculosis?
   [ ] Yes [ ] No
2. Do you have a history of genital herpes? [ ] Yes [ ] No
3. Have you had a viral illness or rash since your last period? [ ] Yes [ ] No
4. Have you ever had chickenpox or the vaccination? [ ] Yes [ ] No
5. Have you been exposed to radiation or chemicals? [ ] Yes [ ] No
6. Do you have any religious objections to any form of medical treatment (i.e. blood transfusion)?
   [ ] Yes [ ] No If so, what: ____
7. Do you feel safe in your home (i.e. domestic violence in the home)? [ ] Yes [ ] No

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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) ____

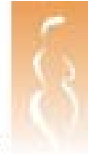
Cardholder Address (Please Print) ____

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_________

The Women's HEALTH GROUP, P.C. 

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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.

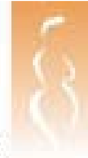
I have read and understand the Financial/Office Policies:

____ _______________________

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**

The Women's HEALTH GROUP, P.C.

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________________________________

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:

____

____

____