Health ONE Colorado Nurse Midwives
Physician Care℠

Routine OB Visit or Well- Woman Visit Financial Consent

If an abnormality is encountered or a preexisting problem is addressed in the process of performing a preventive medicine evaluation and management service (OB revisit, well woman visit, post-partum visit) and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, Colorado Nurse Midwives will bill for both a well woman visit and a problem visit.

When billing Medicare/Medicaid (which specifies its own codes for many preventive services), any additional E/M service must be "carved out" from the preventive service. This portion of the service may be submitted to Medicare/Medicaid for coverage. The Medicare/Medicaid beneficiary may be billed for the difference between the standard fee for the preventive service and the amount that Medicare/Medicaid will cover.

Commercial payers' policies vary. Some will not pay for two evaluation and management services on one date of service, or may reduce payment for one of the services. It is the patient's responsibility to check with your insurance's coding policy, and the patient's benefits.

I understand that if treated for other concerns outside my scheduled visit, I may be charged additional fees.

_____ _____

Name Date

_____ _____

Signature Date of Birth

COLORADO NURSE-MIDWIVES

GYNECOLOGY HISTORY FORM

NAME:_____ Date of Birth:_____ Age:_____

How did you hear about Aurora Nurse Midwives?_____

What is the reason for your visit today?_____

MEDICATIONS / VITAMINS / SUPPLEMENTS

Name	Dose	How Often	What For

MEDICAL HISTORY

Disease / Condition		Disease / Condition	
Diabetes	Yes / No	Thyroid Dysfunction	Yes / No
Hypertension	Yes / No	Trauma / Violence	Yes / No
Heart Disease	Yes / No	History of Blood Transfusion	Yes / No
Autoimmune Disorders	Yes / No	Pulmonary (TB, Asthma)	Yes / No
Kidney Disease / Urinary Tract Infections	Yes / No	Seasonal Allergies	Yes / No
Neurologic / Epilepsy	Yes / No	Breast Problems	Yes / No
Psychiatric / Anorexia / Bulimia	Yes / No	History of Abnormal Pap	Yes / No
Depression / Postpartum Depression	Yes / No	Uterine Anomalies / DES exposure	Yes / No
Hepatitis / Liver Disease	Yes / No	Infertility	Yes / No
Varicosities / Phlebitis	Yes / No	ART Treatment	Yes / No
Other:	Yes / No	Other	Yes / No
If Yes, please explain:			

Vaccine History	Date	Vaccines	Date
Chicken Pox: Disease / Vaccination		Flu	
Tdap (Tetanus, Diphtheria, Pertussis)		Gardasil (HPV)	
Hepatitis B series		Penumonia	
Meningitis		Measles-Mumps-Rubella (MMR)	

ALLERGIES (FOOD, MEDICATION, LATEX, SEASONAL, OTHER)

Name	Reaction	Name	Reaction

PATIENT LABEL

COLORADO NURSE-MIDWIVES

GYNECOLOGY HISTORY FORM

GYN HISTORY

Health Maintenance	**Date**	**Results**	**Health Maintenance**	**Date**	**Results**
Last Breast Exam			**Last Mammogram**		
Last Colonoscopy			**Last Pap**		
Have you ever been treated for an abnormal Pap? Yes / No **If Yes, What? Colposcopy / LEEP / Cone Biopsy**					
Do you do Self Breast Exams? Yes / No,					

Menstrual History	
Are you having periods? Yes / No	If No, Why? Menopause / Birth Control / Hysterectomy / Unknown
Age at onset of periods:	Date of last menstrual period (day it began):
Are your periods regular (monthly)? Yes / No	Frequency: # of days between start of periods:
Are you having problems with your period? Yes / No	If Yes, what?

Sexual History	
Are you sexually active? Yes / No	Is your partner: Male / Female
New partners in the last year? Yes / No	Number of sex partners over your lifetime:
Do you have any problems with sexual intercourse? Yes / No	If Yes, what?

Birth Control History	
Are you using Birth Control? Yes / No	Current Method?
Do you use condoms to help prevent STDs? Yes / No	Would you like Birth Control advice? Yes / No

Infection History		Infection	
genital Herpes?	Yes / No	Gonorrhea	Yes / No
Hepatitis B	Yes / No	Chlamydia	Yes / No
Hepatitis C	Yes / No	HPV / Genital Warts	Yes / No
Syphilis	Yes / No	HIV / AIDS	Yes / No
If Yes, please explain:			

PREGNANCY HISTORY

Have you ever been pregnant? Yes / No, if yes please fill out this section

Total Pregnancies	Full Term	Premature	Elective Abortion	Miscarriage	Ectopic	Multiple Births (twins)	Living

Include Miscarriages and Abortions Below

#	Date (month/year)	Weeks Gestation	Birth Weight	Sex (M/F)	Type of Delivery (vaginal /cesarean /vacuum/forceps)	Comments / complications
1	/					
2	/					
3	/					
4	/					
5	/					

PATIENT LABEL

COLORADO NURSE-MIDWIVES

GYNECOLOGY HISTORY FORM

#	Date (month/year)	Weeks Gestation	Birth Weight	Sex (M/F)	Type of Delivery (vaginal /cesarean /vacuum/forceps)	Comments / complications
6	/					
7	/					
8	/					
9	/					
10	/					

SURGICAL HISTORY

Date (month/year)	Surgery / Complications	Date (month/year)	Surgery / Complications
/		/	
/		/	
Have you ever had any problems with anesthesia? Yes / No, if yes what?			

HOSPITALIZATION HISTORY

Date (month/year)	Reason / Complications	Date (month/year)	Reason / Complications
/		/	
/		/	

FAMILY HISTORY (Unknown? Yes)

Relationship	Alive	Health Problems (diabetes, high blood pressure, heart disease, kidney disease, asthma, TB, Psychiatric, cancers, thyroid disease, epilepsy, hepatitis, other)
Mother	Yes / No	
Father	Yes / No	
Maternal Grandmother	Yes / No	
Paternal Grandmother	Yes / No	
Maternal Grandfather	Yes / No	
Paternal Grandfather	Yes / No	
Brothers, #_____	Yes / No	
Sisters, #_____	Yes / No	
Significant Other/Spouse	Yes / No	
Children, #_____	Yes / No	
1st Cousins		
Aunts		
Uncles		

SOCIAL HISTORY

Substance Use History	Comments
Tobacco Use? Yes / No Years of Use:	Packs/cigarettes per day:
Alcohol Use? Yes / No Years of Use:	What do you usually drink? Drinks per day:
Illicit / Recreational Drug Use? Yes / No Years of Use:	What do you use? How often to you use?

PATIENT LABEL

COLORADO NURSE-MIDWIVES

GYNECOLOGY HISTORY FORM

Personal Safety	Comments
Has anyone close to you ever threatened to hurt you? Yes / No	
Has anyone ever hit, kicked, choked, or hurt you physically? Yes / No	
Has anyone ever forced you to have sex? Yes / No	
Are you afraid of your partner? Yes / No	
Living Environment	**Comments**
Marital Status: Single / Married / Widowed / Divorced / Separated	
Who do you live with?	
Do you have any communication needs? Yes / No Language: English / Spanish / Other:	If Yes, What? Do you need a translator? Yes / No
Living environment: House / Condo / Apartment / Other	
Caffeine Use: Coffee / Tea / Soda / Other:	How many per day?
Environmental Exposure: (circle) chemicals / second hand smoke	
Diet: (circle) Regular / Vegetarian / Vegan / Other	
Do you have any dietary concerns? Yes / No	If Yes What?
Do you Exercise? Yes / No ,What do you do?	How often?
Are you concerned about your weight? Yes / No	If Yes, Why?
Occupation / Work:	
Education / School: Highest Education level completed:	Are you currently in school? Yes / No
Religious Preference:	
Personal Information: Race / Ethnicity:	Place of Birth? Years in USA:
Other: Do you wear a seat belt? Yes / No	

History assisted by MA_____ Date_____

PATIENT LABEL

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

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

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

Patient Registration Form

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other_____

Patient's Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____(First)_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security Number _____-_____-_____ ☐ Female ☐ Male Date of Birth_____/_____/_____

E-Mail Address_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Cellular_____ Pager_____

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Occupation_____

Emergency Contact Name_____ Phone Number_____

Emergency Contact Relationship to Patient_____

Referring Provider Name_____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____(First)_____

Social Security Number _____-_____-_____ ☐ Female ☐ Male Date of Birth_____/_____/_____

E-Mail Address_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Employer Phone Number_____

Patient Relationship to Responsible Party_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-_____-_____

Insurance Company Address_____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-_____-_____

Insurance Company Address_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____