WELCOME TO OUR PRACTICE
PATIENT INFORMATION

Date: _____/_____/_____ Birth Date: _____/_____/_____

Name: _____ Soc. Sec. # _____-_____-_____

Address: _____ City: _____ State: _____

Zip: _____ Home#: ( ) _____ Cell#: ( ) _____

****MAY WE LEAVE A MESSAGE AT THIS PHONE# WITH MSG/ LAB RESULTS)? YES / NO**

Single Married Widow Divorced E-mail: _____

PCP: _____ PCP #: _____

Employer: _____ Work #: _____

Spouse's Name: _____ Birth Date: _____/_____/_____

*****************INSURANCE*****************

Primary Insurance Company: _____
Policy #: _____ Group # _____
Policy Holder: _____ Birth Date: _____/_____/_____

Secondary Insurance Company: _____ _____
Policy #: _____ Group # _____
Policy Holder: _____ Birth Date: _____/_____/_____

*****************If Minor) Who Is Responsible for Account*****************

Name of responsible party: _____ Relation to Patient: _____
Birth Date: _____/_____/_____ Soc. Sec. # _____-_____-_____
Address (if different from patient): _____
City: _____ State: _____ Zip: _____ Phone:(____)_____

*****************Authorization*****************

- ✓ **I certify to the accuracy of the above listed information.**
- ✓ **I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered.**
- ✓ **I authorize the use of this signature on all insurance submissions.**
- ✓ **I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance company.**

Signature _____ Date: _____/_____/_____

NEW PATIENT HEALTH INFORMATION

Date	Name		Age
Date Of Birth	Marital Status	Referred By:	
Occupation	Religious preference (optional)		
Reason for visit today:			
Do you smoke? # per day?	Do you drink alcohol? # per week?	Do you use recreational drug?	
LMP	Cycle length	Duration	Age at 1st menses

OB HISTORY

Date	Length of pregnancy	Vaginal/ C-section	Sex	Birth weight	Complications

Currently sexually active? _____ Sexual preference Male___ Female___ Both___

Please circle Yes or No to all of the following gynecologic conditions you have had:

Menstrual irregularities	yes	no	Pelvic Surgery	yes	no	Abnormal pap smear	yes	no
Ovarian Cysts	yes	no	Pelvic infections	yes	no	Vaginal warts	yes	no
Endometriosis	yes	no	Infertility	yes	no	Chlamydia	yes	no
UTI	yes	no	Uterine fibroids	yes	no	Gonorrhea	yes	no
Urinary leakage	yes	no	HIV	yes	no	Herpes	yes	no

Please circle Yes or No to all of the following medical conditions you have had:

Heart disease/murmur	yes	no	Mental Illness	yes	no	Blood clots	yes	no
Diabetes	yes	no	Migraines	yes	no	Anemia	yes	no
High blood pressure	yes	no	Lung disease	yes	no	Epilepsy	yes	no
Kidney infection/disease	yes	no	Liver disease	yes	no	Eating disorder	yes	no
Ulcer/digestive disease	yes	no	Asthma	yes	no	High Cholesterol	yes	no
Breast disease	yes	no	Thyroid disease	yes	no	Cancer	yes	no
Breast cancer	yes	no	Cervical cancer	yes	no	Uterine/ovarian cancer	yes	no

Please circle Yes or No to all of the following conditions which apply to your family (Children, parents, sisters, brothers, grandparents, first cousins, aunts and uncles.

High blood pressure	yes	no	Mental illness	yes	no	Mental disability	yes	no
Diabetes	yes	no	Thyroid disease	Yes	no	Twins or triplets	yes	no
High cholesterol	yes	no	Stroke	yes	no	Genetic diseases	yes	no
Heart disease	yes	no	Cancer	yes	no	Birth defects	yes	no
Breast Cancer	yes	no	Uterine cancer	yes	no	Ovarian cancer	yes	no

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Immunization history: Gardasil vaccine? (HPV vaccine) 1st_____ 2nd____ 3rd ____
Date of last: Tdap_____ Flu shot _____ Chicken Pox _____

Current Medications (including OTC/supplements)	**Medication Allergies/Reaction** (or medication that can not be tolerated)	**Previous surgeries**

ROCKY MOUNTAIN WOMEN'S CARE
Obstetrics • Gynecology • Fertility

DAVID C. FORSCHNER, M.D.
MATTHEW P. BREEDEN, M.D.
MARGIE P. MAEDER, M.D.
SHANNA M. ROMPEL, D.O.
JEANNE BAIR, D.N.P., C.N.M.

1601 East 19th Ave., Suite 4200
Denver, CO 80218
Telephone: (303) 861-4914
Fax: (303) 861-8615
www.rmwcobgyn.com

CONSENT FOR LAB SERVICES

I am requesting the services of **Rocky Mountain Women's Care, P.C.** for gynecological health care and/or maternity care.
I understand if I am pregnant certain baseline laboratory studies are appropriate and I consent to these studies.

These Include:
Blood Typing, Antibody Screening, Rubella Titer, Serology Status Hepatitis B, Chlamydia/Gonorrhea, HIV, STD, Pap Smear Glucose Challenge, Urine Culture/Urinalysis, Genetic Testing Carrier Screening.

LABS THAT ARE USED:
LABCORP, QUEST, UNIPATH, NXGEN, PROGENITY, NATERA, MATERNIT21 AND INFORMASEQ.

****IT IS MY RESPONSIBILITY AS A PATIENT TO KNOW MY INSURANCE BENEFITS AND WHERE LABS ARE TO BE SENT.**

I hereby authorize payment of insurance benefits to be made to **Rocky Mountain Women's Care, P.C.**. I understand that I am **100%** responsible for all charges, whether or not they are covered by my insurance. I hereby authorize **Rocky Mountain Women's Care, P.C.** to release information necessary to secure the payment of benefits. I further agree that a photocopy of agreement shall be as valid as the orginal.

Print Name of Patient: _____

Signature of Patient: _____

Date: _____

Rocky Mountain Women's Financial Policy

Thank you for choosing Rocky Mountain Women's Care. In order to achieve our goal of providing and maintaining a good physician-patient relationship, we believe it is important to have solid financial policies in place. We also believe that these policies will allow us to provide our patients with high quality, cost-effective care. We ask that you carefully read and sign the following Rocky Mountain Women's Care Financial Policy prior to your treatment.

- Upon arrival, please sign at in at the front desk and present your current health insurance card as well as your driver's license or other acceptable form of ID. You may be asked to present both of these items at each visit for proper identification.
- If you do not have health insurance coverage, choose to bill your own insurance, or if our physicians don't participate in your health insurance plan, payment for all services rendered will be at the time of service.
- You are responsible to make complete insurance information available to Rocky Mountain Women's Care for accurate filing of claims. Complete insurance information includes current benefit cards (primary & secondary), proper ID, and referrals from other providers if applicable.
- You are responsible for checking with your insurance plan regarding any co-payment, deductible, or co-insurance that you may owe at the time of service.
- Co-payments and Deductibles are a contractual obligation with your insurance company. You are required to pay your co-payment and deductibles, and we are required to collect these payments at the time of each visit. Co-payments are collected at the time of service.
- For indemnity-type health insurance plans, insurance payments received by Rocky Mountain Women's Care will be applied to your account and you agree to pay the balance.
- If you have a HMO or PPO health insurance plan and our Rocky Mountain Women's Care physicians participate in your health plan, we will accept payment from the carrier for services covered by your benefit plan.
- Not all services provided by our office are covered by every health insurance plan. Any services determined NOT to be covered by your plan will be your responsibility.
- Rocky Mountain Women's Care, is committed to providing the best treatment for our patients: however, you are a responsible for any unpaid balance regardless of your insurance company's arbitrary determination of usual and customary rates.
- For scheduled appointments, **Prior balances** must be paid or set up on a payment plan prior to your visit.
- We require 48-hour notice for canceling any appointments. A cancelation fee may apply if less than 24 hours.
- A $50.00 fee will be charged for a no show appointment
- A $20.00 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** WELL WOMEN EXAM below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
WELL WOMEN EXAM (PAP AND BREAST EXAM)	ROUTINE NOT COVERED	140.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** WWE listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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CIRCUMCISION – MEDICAID/SELF PAY

Effective July 1, 2011, Medicaid will no longer pay for infant circumcisions.

❖ **By signing this you understand that if you choose to circumcise your infant son, you are responsible for all charges incurred.**

❖ **I have been informed that the circumcision MUST BE PAID IN FULL PRIOR TO DELIVERY.**

CIRCUMCISION FEE = $250.00

PRINT NAME _____ **MEDICAID ID#** _____

SIGNATURE _____ **DATE** _____

e financial Policy and agree to comply and
ue as outlined in the above policy. I agree to
e and to notify this office should there be any

Patient's Printed Name

Patient Signature

Date

Legal guardian Printed Name

Relationship to Patient

Legal guardian Signature

Date