healthy futures

PATIENT DEMOGRAPHICS

Preferred Name: _____

Legal name -Last: _____ First: _____ Middle initial:_____

Date of Birth ____/_____/___ **Sex at birth:** M F **Gender Identity**: M F Trans Other: _____

Preferred Pronouns: She/Her He/Him They/Them Other: _____

Relationship Status: Single Married Divorced Separated Domestic Partner

Race: American Indian/Alaska Native Asian Asian/Pacific Islander Black/African American Caucasian Hispanic Native Hawaiian/Other Pacific Islander Other

Ethnicity: Hispanic/Latino Non Hispanic/Latino

Nationality: _____ **Language:** _____

Street Address: _____

City, State, Zip: _____

Email Address: _____

Home phone # _____ OK to leave messages/results? _____

Cell phone # _____ OK to leave messages/results? _____

Work phone # _____ OK to leave messages/results? _____

Employer Name _____

Emergency contact/who may we speak to on your behalf? _____

& their relationship to you _____ Phone # _____

Parent/Guardian Name _____ Phone # _____

Preferred Pharmacy and Cross-streets of location: _____

Pharmacy Phone Number: _____

How did you hear about our office? _____

PATIENT OR AUTHORIZED PERSON'S AGREEMENT:

I hereby give consent to the providers and staff of Healthy Futures Colorado, PLLC to render such care and treatment as might be required by my condition. I also authorize my insurance company to pay any benefits to my provider. I understand that I am financially responsible for all charges whether or not covered by my insurance. I authorize the release of any medical information necessary to process my insurance claims, and hereby request payment directly to Healthy Futures Colorado, PLLC for services rendered. I also have read and understand the cancellation and no-show policy and agree to those terms. I have been offered a copy of the HIPAA Regulation, which is available to me at the office front desk.

Patient's (Authorized Person's) Signature _____ **Date** _____

Medical history form for hormonal contraception

Do you have any of the following medical problems? (if Yes you should avoid hormonal birth control)
Please circle YES or NO:

Allergy to birth control pills…….	YES NO
History of a blot clot in my leg requiring blood thinners ……	YES NO
History of cancer yourself……	YES NO
Smoke more than 10 cigarettes per day AND age 35 years old or more…….	YES NO
Blood pressure is frequently over 140/90……	YES NO
Jaundice (yellow skin) due to pregnancy or birth control pills……	YES NO
Headaches with unusual symptoms of visual changes, numbness, tingling…	YES NO
Diabetes with known vascular problems…….	YES NO
Coronary artery disease……	YES NO

You should reconsider birth control pills with estrogen in them if you have TWO OR MORE of these problems:

Mild high blood pressure……..	YES NO
Diabetes……	YES NO
High cholesterol……	YES NO
Undiagnosed vaginal bleeding…….	YES NO
Impaired liver function…….	YES NO

Hormonal birth control is very safe as long as you don't have the above concerns.
These are the list of VERY rare complications from hormonal birth control:
Blood clot to the lungs or brain, Heart attack, Stroke, Liver cancer, Jaundice, gallbladder disease, depression.

More commonly cause though less worrisome reactions to hormonal birth control include:
nausea/vomiting, abdominal cramps, bloating altered menstrual flow, breast tenderness, swelling in legs headache, weight loss or weight gain, emotional lability, vaginal irritation, rash, acne, high blood pressure, glucose intolerance

DepoProvera (Medroxyprogesterone) can cause loss of bone density if used for a prolonged number of years.

Hormonal birth control with only progesterone (no estrogen) such as Mirena IUD, Nexplanon (Etonorgestrel) implant, Depo Provera injections and progesterone only birth control pills have less risks of blood clots.

The only non-hormonal long term contraception for women is the Paragard IUD which is 99% effective and lasts 10 years but does cause heavier menstruation.

I understand the advantages and disadvantages of hormonal birth control:

Printed name: _____

Signed name: _____ Date_____

Patient is approved to receive or be prescribed hormonal birth control. (Office use only below line)
Patient may have estrogen containing contraception: _____YES _____NO

Provider Name:_____Provider Signature:_____ Date_____

HEALTHY FUTURES

Financial Agreement for Termination of Pregnancy

I, the patient, understand my choices. I elect to (check one):

☐ Pay Cash, Credit Card (Visa, MasterCard or Discover) or Apple Pay. Once a patient has paid upfront and elected not to use the insurance company, the transaction is final.

☐ Use my insurance company and provide Healthy Futures with valid credit card information that I authorize them to use if the insurance company changes their mind and refuses to pay for services at all. The credit card information will be held in a company safe until the balance is cleared and then information will be destroyed.

Patient signature: _____ Date: _____

Complete the information below ONLY if you intend to use your insurance company

I (patient name): _____ on date _____ understand that….

- Insurance companies often will state that they will pay for a procedure and then they do not. If they do not, Healthy Futures will expect the patient to pay.
- Healthy Futures can offer a dramatic discount if the patient pays directly for the procedure and leaves the insurance company out of it. In your case the fee we would off you, if you were willing to pay directly as a final transaction would be $_____; but if you choose to go through insurance and they tell us before that they will pay and afterwards the insurance company refuses to pay at all then the figure will be $_____.
- If the patient intends to use the insurance company, Healthy Futures will collect my credit card information before the procedure begins, and use it if/when the insurance company changes their mind and refuses to pay. We will call you the day we run your card to inform you..
- To use an insurance company the first step is to calculate what amount is the "patient responsibility"--the copay and deductible that may apply. Our best estimate of that amount is your copay of $_____ and your deductible of $_____ for a total of $_____. Healthy Futures will collect it before the procedure starts. In several weeks, when the insurance company has decided if and how much they might pay us, we may refund you some money or you may owe us some money but we will try and be as accurate as possible at the beginning.
- I (patient name) _____ agree to provide Healthy Futures Colorado, PLLC with valid credit card information so that in the event that my insurance company first says they will pay, then later refuses to pay, Healthy Futures has my permission to charge my credit card for the remaining balance.

The type of credit card: MC VISA DISCOVER
The number is _____=_____=_____=_____
Expiration date: _____ 3 digit security code: _____
The maximum amount to be charged, if the insurance company were to pay nothing, is $_____

Signature of card holder: _____ Date: _____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patients rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **YES** **NO**

May we leave detailed messages on your home or cell phone? **YES** **NO**

May we discuss your medical condition with any member of your family? **YES** **NO**

If YES, please name the members allowed:

_____

Printed name of the Patient:_____

Signature:_____ Date:_____