

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



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](http://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](http://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](mailto: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?** \_\_\_\_\_

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**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 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.*

<b>CONSTITUTIONAL</b>	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Weight Gain
	<input type="checkbox"/> Other _____		
<b>EYES</b>	<input type="checkbox"/> Glasses/Contacts	<input type="checkbox"/> Other _____	
<b>HEAD/NECK</b>	<input type="checkbox"/> Sinus Congestion	<input type="checkbox"/> Dentures	<input type="checkbox"/> Decreased Hearing
	<input type="checkbox"/> Other _____		
<b>BREAST</b>	<input type="checkbox"/> Lumps	<input type="checkbox"/> Tenderness	<input type="checkbox"/> Nipple Discharge
	<input type="checkbox"/> Other _____		
<b>CARDIOVASCULAR</b>	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Fainting
	<input type="checkbox"/> Other _____		
<b>RESPIRATORY</b>	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Cough
	<input type="checkbox"/> Other _____		
<b>GASTROINTESTINAL</b>	<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 _____
<b>GENITOURINARY</b>	<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 _____
<b>SKIN</b>	<input type="checkbox"/> Rash	<input type="checkbox"/> Changes in Moles	<input type="checkbox"/> Changes in Lesions
	<input type="checkbox"/> Other _____		
<b>NEUROLOGICAL</b>	<input type="checkbox"/> Muscular Weakness	<input type="checkbox"/> Incoordination	<input type="checkbox"/> Tingling/Numbness
	<input type="checkbox"/> Other _____		
<b>MUSCULOSKELETAL</b>	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Muscle Pain	Other _____
<b>ENDOCRINE</b>	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Constant Drinking	<input type="checkbox"/> Cold Intolerance
	<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Other _____	
<b>PSYCHIATRIC</b>	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Difficult Sleeping
	<input type="checkbox"/> Other _____		
<b>HEME-LYMPH</b>	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Lymph Node Pain
<b>ALLERGIC-IMMUNE</b>	<input type="checkbox"/> Sinus Symptoms	<input type="checkbox"/> Frequent Illness	<input type="checkbox"/> Other _____
<b>MENSTRUAL HISTORY</b>	Menses began _____ y/o    Cycle Interval _____ days    Duration _____ days		
	<input type="checkbox"/> light	<input type="checkbox"/> medium	<input type="checkbox"/> heavy    Last period _____
Birth Control Method _____	<input type="checkbox"/> Home Pregnancy Test <input type="checkbox"/> Positive <input type="checkbox"/> Negative		
<input type="checkbox"/> Peri-menopause	<input type="checkbox"/> Menopause Age began _____		

The Women's Health Group, P.C.  
9195 Grant Street, Suite 410                      300 Exempla Circle, Suite 470  
Thornton, CO 80229                                      Lafayette, CO 80026

***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 90 days. *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.* By enrolling in *Simple Solutions*, the "Patient Responsibility Amount" shown on my Explanation of Benefits (EOB), will be transferred to my credit card as listed below.

**Automatic payment will be transferred to my credit card:**

- Upon the physician's receipt of insurance EOB (preferred)
- Per payment plan arrangements with Billing Account Manager
- End of the month
- Each visit

**Options:**

- Use my credit card automatically
- I prefer a courtesy call (phone) \_\_\_\_\_ or (email) \_\_\_\_\_ to alert me to the billing date.

**If no response is received by the office within five business days, my credit card will be charged automatically.**

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 is valid for one year from date of signature or upon my notification to The Women's Health Group IN WRITING prior to the next billing cycle.**

Patient Name \_\_\_\_\_ Phone: \_\_\_\_\_

Cardholder Name (Please Print) \_\_\_\_\_

Cardholder Address (Please Print) \_\_\_\_\_

City, State, Zip (Please Print) \_\_\_\_\_

Circle one:    Visa    MasterCard    Discover

Credit Card Number \_\_\_\_\_ Exp: \_\_\_\_\_ Security Code \_\_\_\_\_

For office use only:  
Account Number \_\_\_\_\_

**PRIVACY NOTICE ACKNOWLEDGEMENT**

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

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\*\*A copy of the Privacy Practices can be found on our website on the Forms page. Signing this acknowledgement confirms you are aware of our Privacy Policy. If you would like a paper copy of our policy, please ask the receptionist.

## 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

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### QUESTIONS I WANT TO REMEMBER TO ASK THE DOCTOR:

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