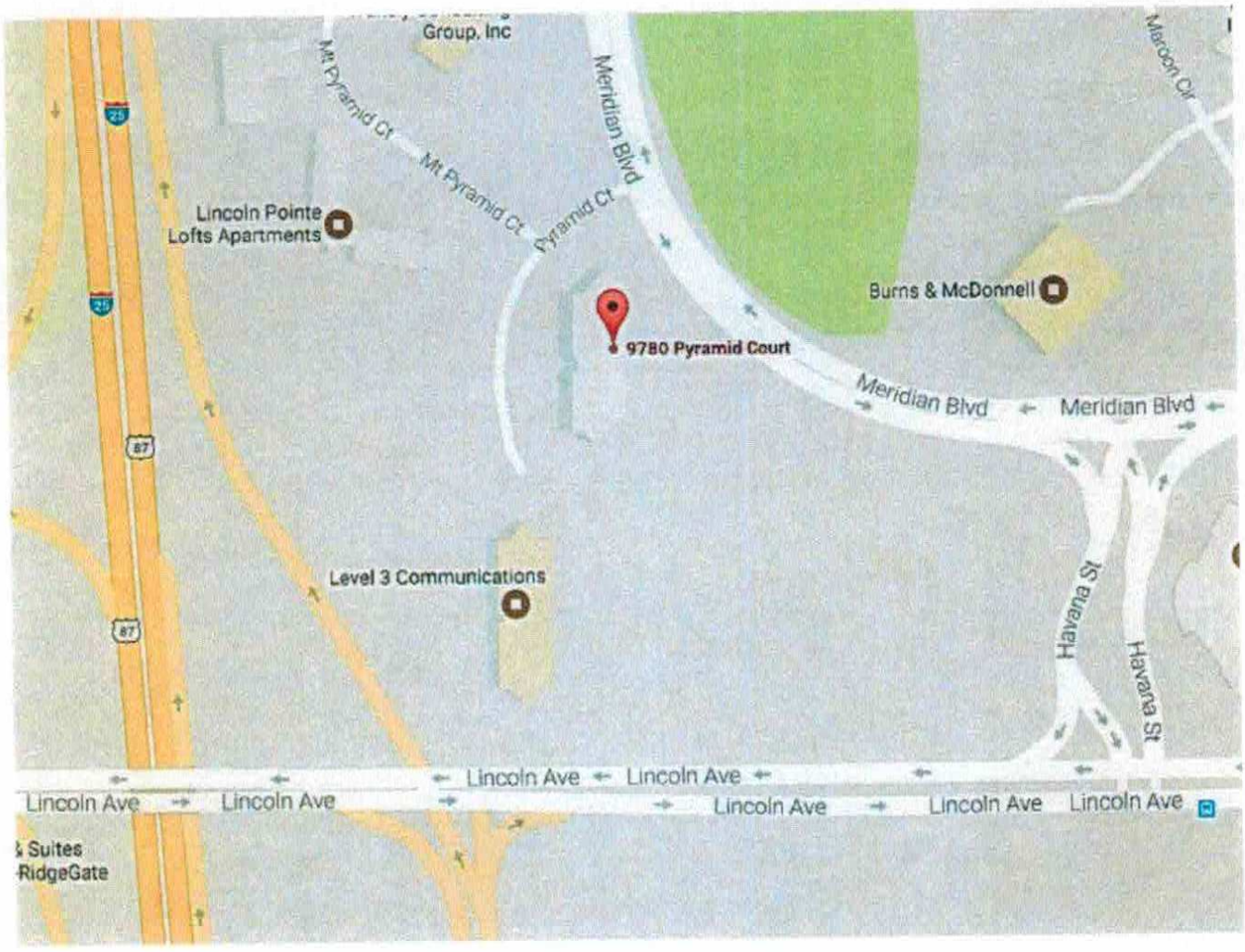
Directions to Denver Fertility/Albrecht Women's Care

9780 Pyramid Court, Ste. 260
Englewood, CO 80112
720-420-1570

We are located on the northeast corner of I-25 and Lincoln Avenue.

- ✓ From I-25, go east on Lincoln Ave.
- ✓ Turn left (north) on Havana St. and stay in the left lane.
- ✓ Turn left at the light - Meridian Blvd (you will veer west).
- ✓ Turn left on Pyramid Ct.
- ✓ We are the first building on the left.
- ✓ Suite 260



PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: _____ **DOB:** _____
First M.I. Last

Address: _____ _____ _____ _____
Street / Apt # City State Zip

Primary Phone: _____ **Alternate Phone:** _____

Employer: _____ **Occupation:** _____

Email: _____

Sex: ☐ Female ☐ Male **Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Primary Care Physician: _____ **OB/GYN Physician:** _____

How did you hear about our office? ☐ Referring Physician: _____ ☐ Patient/Friend: _____

☐ Other : _____ ☐ Our Website ☐ Online Review ☐ Google ☐ Social Media

_____ ☐ Online Ad ☐ TV ☐ 5280 Magazine ☐ Women's Edition Magazine

PHARMACY

Name: _____ **Phone (REQUIRED):** _____

Address: _____

SPOUSE/PARTNER INFORMATION or EMERGENCY CONTACT

Name: _____ **DOB:** _____

Primary Phone: _____ **Relationship:** _____

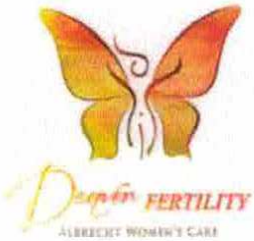
INSURANCE

Primary Insurance: _____
Claims Address: _____
_____
Phone Number: _____
ID Number: _____
Group Number: _____
Effective Date: _____
Policy Holder Name: _____
DOB: _____
SSN: _____

Secondary Insurance: _____
Claims Address: _____
_____
Phone Number: _____
ID Number: _____
Group Number: _____
Effective Date: _____
Policy Holder Name: _____
DOB: _____
SSN: _____

The above information I have given is true and correct. I understand that I am ultimately responsible for payment of all services. If billing my insurance; I authorize payment of medical benefits to undersigned Denver Fertility/Albrecht Women's Care for their services and all future claims. I authorize the release of any medical information necessary to process this claim and all future claims.

_____ _____
Patient Signature Date



AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI may be made by alternative means; for example, sending correspondence to the individual's email instead of the individual's home address.

I give Denver Fertility/Albrecht Women's Care permission to contact me by the following means;

CHECK ALL THAT APPLY

■ **Telephone:** _____

- ☐ OK to leave a message with detailed information
- ☐ OK to leave a message with other family members
- ☐ OK to discuss my health information with spouse or partner; **Name:** _____
- ☐ Do not leave a message

■ **Email:** _____

- ☐ OK to contact me via email and/or email me with detailed information
- ☐ Do not contact me by email

■ **Written Communication**

- ☐ OK to send mail to my home address
- ☐ OK to send mail to my work/office address
- ☐ OK to fax to this number: _____

■ **Other:** _____

IF YOU ARE A MINOR:

- ☐ OK to release information to parent or guardian; **Name:** _____
- ☐ Do not release information to anyone other than myself

NOTE: Uses and disclosures may be permitted without prior consent in case of an emergency.

_____ _____

Print Patient Name Date of Birth

_____ _____

Patient Signature Date

Notice and Acknowledgement of Privacy Practices

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that Denver Fertility/Albrecht Women's Care and all staff members continually undergo training so that we may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We are required by law to maintain the confidentiality of health information that identifies you. The Department of Health and Human Services has established a "Privacy Rule" to help insure that your personal information is protected from unnecessary distribution. The Privacy rule has also been created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or other health care operations. We strive to achieve the very highest standards of ethics, integrity, and quality in performing services for our patients. As our patient, we want you to know that we respect the privacy of your personal medical records, and we will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. None of your private information will be released to anyone without your expressed written consent. It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a compliance program that we believe will help us prevent an inappropriate use of PHI. We also want you to know that we support your full access to your personal medical records. Other businesses that we deal with may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients). In cases such as these, we may have to disclose some personal health information for purposes of treatment, health care operations, or payment. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your personal health information. Should you refuse to disclose your personal health information to us, we have the right to refuse to treat you under the law. Should you disclose your information to us, but refuse it to your insurance company, you will be responsible for the full balance on your account at the time of service.

WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE PERSONAL HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

1. **Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice including, but not limited to; our doctors, nurses, medical assistants, laboratory personnel, or indirectly with any provider we refer you to, may use or disclose your PHI in order to treat you. Additionally, we may need to disclose your PHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits and for what range of benefits. We may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover or pay for your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for costs; such as families or insurance companies. Also, we may use your PHI to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations; our practice may use your PHI to evaluate the quality of care you receive from us or to contact cost-management and business planning activities for our practice.
4. **Appointment Reminders/Emails.** Our practice may use and disclose your PHI to contact you or a family member who answers the phone (or to leave a voicemail) to remind you of an upcoming appointment. We may also send you emails that others may have access to.
5. **Treatment Options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends**. Our practice may release may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required by Law.** Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

USE AND DISCLOSURE OR YOUR PHI IN CERTAIN CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purposes of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence)
- Notifying your employer under limited circumstances related primarily to workplace injury, time off work, illness or medical surveillance

2. **Health Oversight Activities.** Our practice may disclose your PHI to a health oversight agency for activities authorized by law.
3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceedings. We also may disclose you PHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.
4. **Law Enforcement.** We may release PHI if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations
   - Concerning a death we believe has resulted from criminal conduct
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, material witness, fugitive or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)
5. **Deceased Patients.** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death.
6. **Organs and Tissue Donation.** Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
7. **Serious Threats to Health or Safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
8. **Military.** Our practice may disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
9. **National Security.** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
10. **Inmates.** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
11. **Workers' Compensation.** Our practice may release your PHI for workers' compensation and similar programs.

I acknowledge that I have read this Notice of Privacy Practices; which describes ways in which Denver Fertility/Albrecht Women's Care may use and disclose my healthcare information for its treatment, payment, healthcare operations, and other described and permitted uses and disclosures. I understand that I may contact the office if I have a question or complaint. I understand that this information may be disclosed electronically by Denver Fertility/Albrecht Women's Care. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in this document.

_____ _____

Print Patient Name Date of Birth

_____ _____

Patient Signature Date

FINANCIAL POLICY

Thank you for choosing Denver Fertility/Albrecht Women's Care. We are committed to providing you with quality and affordable healthcare. The following information is provided to help you understand our financial policies.

Required Information. Prior to any services being provided, we must obtain a current insurance card, a photo ID, and a completed patient information packet. If you do not have insurance or an up-to-date and correct insurance card, you will be responsible for payment at the time of service.

Insurance Benefits. We participate with most insurance plans. We recommend that you check with your insurance company to determine what your insurance benefits are prior to your first appointment; as knowing your benefits is your responsibility. If we do not participate with your insurance, payment in full is due at the time of service.

Co-Payments and Deductibles. All co-pays and deductibles must be paid at the time of service and are a part of your contract with your insurance company.

Non-Covered Services. Please be aware that some, and perhaps all, of the services you receive may not be covered or not considered reasonable or necessary by your insurance company. If this is the case, you must pay at the time of service.

Claims Submission. We will submit claims on your behalf to your insurance company. Occasionally, your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you. If you do not wish to have your services submitted to your insurance, you can opt for the self-pay discount. This discount is **ONLY** available when paid at the time of service. If you choose this option, we will not be able to bill your insurance company at a future date.

Insurance Coverage Changes. If your insurance changes, it is your responsibility to notify us of any changes.

Self-Pay Discount. If you do not have insurance or your insurance will not cover services, we offer a self-pay discount. This discount will **ONLY** be given if paid at the time of service.

Credit Card Policy. At the time of your first visit, you will be asked for a credit card number to be placed on file in your electronic medical record (EMR). This information will be held securely in your EMR. After the insurance company has paid their portion of the charges and notified us of the remaining balance owed by you, your credit card will be charged. A copy of the charge and a receipt will be sent to you for your records. This policy in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. We will charge you the portion that your insurance company has determined is your responsibility. If the balance is large, the billing office will contact you prior to charging your credit card. Co-pays are still due at the time of service and must be paid at that time.

Non-Payment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated with our billing office. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. Patients will be responsible for the cost of collection efforts such as; referring the account to a collection agency or attorney fees. If your account remains unpaid, you and your immediate family members may be discharged from the practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, we will only be able to treat you for emergency problems.

Missed Appointments. Our policy is to charge for missed appointments that are not canceled within a reasonable amount of time. These charges will be your responsibility and will be billed directly to you, not your insurance company.

I acknowledge that I have read and understand the above information regarding the financial policies of Denver Fertility/Albrecht Women's Care.

Printed Patient Name	Signature	Date

REQUEST FOR RELEASE OF MEDICAL RECORDS

Last Name _____ First Name _____ M.I. _____ DOB _____

Street Address _____ City _____ State _____ Zip Code _____

Phone _____ Other Name(s) - If applicable _____

RECORDS TO BE RELEASED FROM:

Practice/Physician Name _____

Street Address _____ City _____ State _____ Zip Code _____

Phone _____ Fax _____

RECORDS TO BE SENT TO:

Denver Fertility / Albrecht Women's Care
9780 Pyramid Court, Suite 260
Englewood, CO 80112
Fax: 866-657-9471 or **Email: info@albrechtwomenscare.com**
Phone: 720-420-1570

Records of care from (dates): _____ to _____

____ Complete Medical Record ____ Laboratory Reports ____Medical Imaging Reports
____ Pathology Reports ____ Surgical Records
____ Other (specify): _____

I understand by signing this release form, I give my permission to release my confidential information to the above named physician/clinic. My signature also authorizes the release of any information relating to AIDS or HIV testing, alcohol use, or mental status contained in my records. I understand I can revoke this request at any time in writing, except to the extent that action has already been taken.

Signature: _____ Date: _____

Witness: _____ Date: _____

Appointment Date and Time: _____

ALBRECHT WOMENS CARE
"We Aim for Perfection"

FEMALE MEDICAL HISTORY

Date of Appointment: _____ Last Name: _____ First Name: _____ DOB: _____

Age: ___ Marital Status: M ☐ S ☐ Partner's Name: _____ Age: ___

How did you hear about our office? _____

What is the reason for your appointment today? _____

What was the first day of your last menstrual flow? _____ Your age of your first menstrual flow: _____

What is the length of your menstrual cycle? (Days between the first day of one period to the next): _____

How many days does the flow last? _____ How many are heavy? _____

Do you have spotting or bleeding between periods? Yes ☐ No ☐

What is the number of pads or tampons used in 24 hours on heavy days? Pads ____ Tampons ____

Do you use tampons and pads together? Yes ☐ No ☐

Do you soak through? Yes ☐ No ☐ If so how often? _____

Do you have menstrual cramps? Yes ☐ No ☐

If yes, are they? Mild ☐ Moderate ☐ Severe ☐ How many days? ____

Do you use any medications for menstrual cramps? Yes ☐ No ☐ If yes, please list the medications below: _____

_____

Do you take any prescription medications? If yes list the medication the reason and how often it is taken.

_____

_____

Do you take any over-the-counter medications? If yes, list the medication the reason and how often it is taken.

_____

_____

Allergies And Adverse Reactions

If you have had an adverse reaction to medication, chemicals, insect bites, insecticides, foods, etc., please list with an explanation of your reaction and the severity: _____

Pregnancy History

How many times have you been pregnant (include miscarriages & abortions)?

term deliveries _____ # of preterm deliveries _____ # of miscarriages _____ # of ectopic pregnancies ____

of therapeutic abortions _____

Please complete the following for each pregnancy:

	Year	Outcome* (Use key below)	How Long to to Conceive?	Father Current/Past		Sex	Weight
1st Pregnancy	____	____	____	C	P	____	_____
2nd Pregnancy	____	____	____	C	P	____	_____
3rd Pregnancy	____	____	____	C	P	____	_____
4th Pregnancy	____	____	____	C	P	____	_____
5th Pregnancy	____	____	____	C	P	____	_____

* Vaginal delivery (V), C-Section (CS), Miscarriage (M), Abortion (A), Ectopic Pregnancy (EP)

Were there any complications during or after your pregnancies?

Please check if you have ever had:

Uterus removed
Uterine fibroids
Uterine Polyp(s)
Uterine hyperplasia
Uterine cancer
D&C
Hysteroscopy
Ovaries removed
Ovarian cysts
Ovarian cancer

Endometriosis
Pelvic Pain
PID
Pain with Intercourse
Polycystic ovarian syndrome (PCOS)
Infertility
Hot flashes
Vaginal dryness

Cervix frozen
Cervical biopsy
LEEP of cervix
Cervical cancer
Vulvar cancer

Genital Warts
Genital herpes
Gonorrhea
Chlamydia
Trichomonas
Syphilis
Mycoplasma
Yeast infection

Do you use any contraception? Y ☐ N ☐ If yes, please list: _____

What contraception have you used in the past? Please check all that apply.

None
Rhythm
Birth control patches
Diaphragm

Sponge
Depo-Provera injection
Tubal ligation
Condoms

Norplant/implants
Birth control pills
Nuvaring

Foam/jellies
Withdrawal
IUD

Date of your last mammogram _____ Was it normal? Y ☐ N ☐

Have you or do you currently have?

Breast Cancer
Augmentation

Fibrocystic Breasts
Nipple discharge

Breast Lump(s) removal
Reduction surgery

How often do you examine your breasts? _____

Date of last Pap smear: _____ Was it normal? Y ☐ N ☐

Have you had abnormal Pap smears? Y ☐ N ☐ If yes, when and what was the abnormality? _____

What is the frequency of your sexual activity? _____/week _____/month

Do you have pain with sexual intercourse? Y ☐ N ☐

Do you or your partner use lubricants when engaged in sexual activity? Y ☐ N ☐

What is your sexual orientation? Heterosexual ☐ Lesbian ☐ Bisexual ☐

Have you ever been abused sexually, physically or emotionally? Y ☐ N ☐

Surgical History

Please list any type of surgery you have had:

Type of Surgery	date	year	Type of Surgery	date	year
_____	____	____	_____	____	____
_____	____	____	_____	____	____

Medical History (Please check all that apply)

abdominal aneurysm
abnormal chest x-ray
abnormal kidney
AIDS
alcoholism/alcohol trouble
anemia
asthma
angina (chronic heart pain)
bleeding problem
blood clots
cataracts
chronic back pain
colon cancer
colon polyps
contact lenses/glasses
degenerative arthritis
dentures
depression
diabetes
drug abuse
eating disorder
eczema
emphysema
fecal incontinence
gallstones
glaucoma
gout
hay fever
hearing loss
heart attack
heart murmur
hepatitis/liver disease
hemorrhoids
herniated disc
hiatal hernia
high blood pressure
high cholesterol
HIV positive
irritable bowel
kidney stones
leukemia
lung cancer
migraines
pacemaker
pancreatitis
psoriasis
rheumatic fever
rheumatoid arthritis
seizures
skin cancer
spastic colon
stroke/TIA
thyroid problems
tuberculosis
ulcers
ulcerative colitis

Social History

What is your occupation? _____ What is your ethnic heritage? _____
(German, Italian, African-American, Ashkenazi Jewish, etc.)

What do you do for exercise? _____ How many days/week? _____ How many minutes? ____

Do you smoke? Y ☐ N ☐ How many years did you or have you smoked? _____

When did you quit? _____ How much alcohol do you drink? _____ per day ____ per week _____ per month

Have you considered suicide? Y ☐ N ☐ Have you attempted suicide? Y ☐ N ☐

Do you use any recreational drugs? Y ☐ N ☐ If yes, which ones? _____

How much caffeine do you drink per day? Coffee _____ Tea _____ Soda _____

Do you follow a special diet? Y ☐ N ☐ If yes, what kind? _____

Do you or have you had an eating disorder? Y ☐ N ☐ If yes, what kind? _____

Do you take calcium supplements? Y ☐ N ☐ If yes, what kind and how much? _____

Do you take vitamins or other supplements? Y ☐ N ☐ If yes, what kind and how much? _____

_____

What is your religious affiliation? _____ Do you observe religious traditions? Y ☐ N ☐

If yes which ones? _____

Have you ever received a blood transfusion? Y ☐ N ☐ If yes, why? _____

Have you been turned down as a blood donor? Y ☐ N ☐ If yes, why? _____

What is your blood type? ____ Height _____ Weight _____

Have you traveled to a foreign country within the last year? Y ☐ N ☐ If yes, what country? _____

_____

Are you immune to rubella (German measles)? Y ☐ N ☐ Unknown

Have you had the Chicken Pox or the vaccine series? Y ☐ N ☐ Unknown

Family Cancer History

Have you had any relatives with any form of cancer? Y ☐ N ☐ If yes, please list who and what type of cancer:

_____

_____

Family Tree

Please list the names and ages of your immediate relatives. Also, please list any health problems that your relatives may have/had. If deceased, please indicate age at death, cause of death and any other health problems. If adopted please check the box to the right and skip to the next section.

Mother's name: _____ Present age? _____ Age at death? _____ Health problems and/or cause of death: _____

Maternal Grandmother's name: _____ Present age? _____ Age at death? _____ Health problems and/or cause of death: _____

Maternal Grandfather's name: _____ Present age? _____ Age at death? _____ Health problems and/or cause of death: _____

Father's name: _____ Present age? _____ Age at death? _____ Health problems and/or cause of death: _____

Paternal Grandmother's name: _____ Present age? _____ Age at death? _____ Health problems and/or cause of death: _____

Paternal Grandfather's name: _____ Present age? _____ Age at death? _____ Health problems and/or cause of death: _____

Please list all of your siblings and children:

Name	Relationship	Present Age If living	Age at death	Health problems and/or cause of death

Please give details of any family history you think may be relevant to your situation: _____