

**Women's Clinic of Northern Colorado**

**Statement of Agreement:**

**Care**

***After hours care:***

In an effort to allow each woman to receive care in a timely and appropriate manner, after hours care will be provided in the following manner:

- Urgent or Emergent care by a WCNC physician or certified nurse midwife is available 24/7 on call.
- After hours care is triaged through our qualified nurse staffed answering service.

***Reflex Testing:***

Pap tests may reveal that a patient is at risk for the HPV virus. If your test reveals this, WCNC authorizes the pathologist to automatically order the High Risk Strain HPV test. If you are over the age of 30, this HPV test will automatically be ordered every third year. Tests will be billed to you and your insurance by the pathology provider. If you choose to not allow reflex testing, please inform your nurse or provider, **and please sign here:** \_\_\_\_\_

***Pregnancy and Medication Risks:***

Please inform you provider of all medications, herbal supplements, vitamins, prescriptions, over the counter drugs, legal or illegal drugs that you are currently taking or have taken if you are:

- Pregnant
- Attempting to become pregnant
- Having unprotected intercourse

***Mammograms:***

WCNC supports the American Cancer Society ([www.cancer.org](http://www.cancer.org)) guidelines as follows:

Over 20	<b>Breast Self Exam</b>	Monthly	Report changes/symptoms to your health professional
20-39	<b>Clinical Breast Exam</b>	Every 3 years	
40+	<b>Clinical Breast Exam</b>	Every year	
40+	<b>Mammogram</b>	Every year	Or as may be recommended by your provider

**Privacy Practices**

**I have been offered the opportunity to review, read and understand the WCNC Notice of Privacy Practice.**

I hereby consent that my health records may be disclosed to necessary parties for the purposes of my treatment, payment and health care services.

I understand I may revoke my consent at any time; however WCNC is not required to accept my request. Revocation form must be completed and returned to the WCNC to be enforced and in effect the day it is received by WCNC.

**Financial Obligations**

I am obliged to understand and agree to the services rendered to me by WCNC providers.

I agree to be financially responsible for the services received regardless of insurance coverage.

I agree to pay my balance in full upon receipt of WCNC Statement or letter requesting such payment.

I understand and agree that any balance over 30 days old will incur a billing service charge.

I authorize the release of any information necessary to process my claims.

I irrevocably assign all benefits for claims by WCNC to the provider of service.

Any money over and above my indebtedness for claims will be refunded to me when my total account is paid in full.

\_\_\_\_\_  
Patient Signature  
(sticker)

Date: