

**Women's Clinic of Northern Colorado**  
**Care Agreement**

**After hours care:**

- 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. We recommend HPV testing with a Pap smear for all patients 30 years and older. If both tests are normal, you will only need a Pap smear 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 clinical staff and your provider.

- I Accept       I Decline the high-risk HPV testing.      \_\_\_\_\_ Staff initials

**Gonorrhea & Chlamydia Testing:**

WCNC recommends routine gonorrhea and Chlamydia testing for all women 25 and under. This will be done at the same time as your Pap. If you choose to decline this testing, please inform clinical staff and your provider.

- I Accept       I Decline Gonorrhea & Chlamydia testing       N/A \_\_\_\_\_ Staff initials

**Medication History:**

Electronic prescribing enables access to your medication history for any prescriber, which allows your WCNC provider to prescribe medication for you more effectively. Do you agree to access of your medication history by WCNC staff?

- I Agree       I Do Not Agree to access of my medication history by prescribers other than WCNC

**Colorado Prescription Drug Monitoring Program**

If you receive a prescription for a "controlled" (Schedule II through V) drug, your identifying prescription information will be entered into Colorado's electronic Prescription Drug Monitoring Program (PDMP) database when this drug is dispensed to you and may be accessed for limited purposes by specified individuals. You have a right to access your information in the PDMP through the Colorado Board of Pharmacy. You may seek corrections to the information as you would with your other medical records.

**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, agree, and be financially responsible for services rendered to me by WCNC providers. I agree to pay my balance in full upon receipt of WCNC Statement or letter requesting such payment. I understand and agree that balances over 30 days old will incur a service charge and be considered past due. I authorize the release of any information necessary to process my claims and irrevocably assign all benefits for claims to WCNC.

Patient Signature

Date