DUBLIN PRIMARY CARE

2685 Dublin Boulevard
Colorado Springs, CO 80918
(719) 592-9890

Routine Physical Examination and/or Well Woman Exam

Our records indicate that you have been scheduled today for a Routine Physical Examination and/or a Well Woman Exam. The exams are also known by but not limited to, the following terms:

Routine Physical Examination
Annual Exam or Annual Check up
Yearly Exam or Yearly Check Up
Complete Physical Examination (CPE)
Healthcare Maintenance Exam (HCM)
Well Adult Exam
Physical
Preventive Maintenance Exam

Well Woman Exam
Annual Pap and Pelvic Exam
Pap
Pap/Pelvic/Breast Exam
WWE
A Female Exam
Yearly, Routine, Female Exam

This service will be coded by our office as a "Routine Physical Examination" and/or a "Well Woman Exam." Your insurance MAY or MAY NOT cover this exam.

If you or the healthcare provider you are seeing today, decide to have LAB WORK done, please note that the reference laboratory contracted by your insurance company will bill the insurance company for all laboratory tests performed by them. The laboratory services May or MAY NOT be covered by your insurance plan as part of the "Routine Physical Examination" and/or the "Well Woman Exam."

Please keep in mind that services provided today that go above and beyond the normal scope of a "Routine Physical Examination" and/or a "Well Woman Exam" will be billed to your insurance company with the appropriate diagnosis and office visit codes. It is your responsibility to know if you have insurance benefits for wellness, preventive, well woman or health screening. All services for today's visit, whether billed by this office or the reference laboratory that are not paid by insurance, are your financial responsibility.

The physicians and healthcare providers of Dublin Primary Care feel that periodic, routine physical examination with certain diagnostic laboratory test or other age appropriate procedures, are an integral part of providing excellent healthcare to their patients.

By signing below you acknowledge and accept financial responsibility for all non-covered services, and/or services that your insurance company delegates as your responsibility that are associated with today's visit.

Patient Printed Name

Date of Service

Signature of Patient
(Or Guardian/Guarantor if patient is a minor)

Patient Date of Birth