Lake Champlain Gynecologic Oncology

Please fill out this form completely and indicate with N/A where applicable. If not completed in it's entirety our front end staff will return and ask that you complete missing information.

REGISTRATION FORM

LAST NAME_____ FIRST NAME_____MIDDLE INITIAL_____

MAILING ADDRESS_____

STREET ADDRESS_____

CITY_____STATE_____ZIP_____

DATE OF BIRTH _____/_____/_____SOCIAL SECURITY NUMBER_____-_____-_____

RACE _____ ETHNICITY_____LANGUAGE_____

HOME#_____CELL#_____MARITAL STATUS_____

PHARMACY & ADDRESS _____

PRIMARY CARE PROVIDER_____PHONE_____

REFERRING PHYSICIAN (New Patient)_____PHONE_____

EMERGENCY CONTACT & RELATIONSHIP_____PHONE_____

EMPLOYER INFORMATION

COMPANY NAME_____WORK PHONE_____EXT_____

ADDRESS_____CITY_____ST._____ZIP_____

CONSENT FOR GENERAL MEDICAL TREATMENT

This is to certify that I, the undersigned, hereby voluntarily consent to treatment at Lake Champlain Gynecologic Oncology, and such diagnostic procedures and medical care by the attending physician, and designates, as is necessary in their judgment. I acknowledge and understand that the practice of medicine is not an exact science, and that no promises or guarantees have been made concerning the outcome of results of my care and treatment received from Lake Champlain Gynecologic Oncology.

CONSENT TO OBTAIN or RELEASE PATIENT INFORMATION

I HEREBY AUTHORIZE Lake Champlain Gynecologic Oncology to **REQUEST** from any physician or physician group medical information/records pertaining to my care. **I ALSO HEREBY AUTHORIZE** Lake Champlain Gynecologic Oncology to **RELEASE** to any group involved in my care. All information contained in the medical record of the above named patient to any third party payer for whom I may seek payment or reimbursement for expenses related to my treatment: to any entity having responsibility for review, investigation, claim processing, utilization review, or financial audit, in respect to payment for care rendered by Lake Champlain Gynecologic Oncology or any governmental agency requesting information for lawful purposes.

SIGNATURE DATE WITNESS IF GUARANTOR HAS SIGNED

Lake Champlain Gynecologic Oncology

INSURANCE FORM

PRIMARY INSURANCE INFORMATION

Subscriber Name_____Relationship_____

Date of birth of subscriber (if other than self) _____

Insurance_____Copay_____

ID#_____Group#_____

Effective date_____ Expiration date _____

Medicare Part D-RX ID_____
(If applicable)

SECONDARY INSURANCE INFORMATION

Subscriber Name_____Relationship_____

Date of birth of subscriber (if other than self) _____

Insurance_____Copay_____

ID#_____Group#_____

Effective date_____ Expiration date_____

BILLING INFORMATION

It is the patient's responsibility to see that referrals are obtained prior to their appointment if one is needed in accordance with your insurance plan. If there are any changes related to your insurance information (new company, change of ID #, billing address, etc.) it is your responsibility to notify us of these changes at the time of the appointment. If charges are incurred due to any of the above reasons, the patient will be responsible and billed directly. **There will be a $25.00 fee for any missed visit or visits cancelled within 24 hours of the appointment.** These charges are not covered by insurance and will be billed directly to you.

AUTHORIZATION TO ASSIGN INSURANCE BENEFITS

By signing this form the patient (or the policyholder, if the patient is not the policyholder) hereby authorizes and directs that all medical benefits payable to or for the benefit of the Patient under the terms of any applicable insurance policy, be paid directly to Lake Champlain Gynecologic Oncology. By signing this form the patient authorizes Lake Champlain Gynecologic to appeal any claims on their behalf to ensure proper payment of a claim(s). Patient agrees to sign any additional assignment of benefit forms requested by Lake Champlain Gynecologic Oncology or any insurance company from time to time. Patient understands that she is liable to Lake Champlain Gynecologic Oncology for all related charges, whether or not covered by the insurance company. **PLEASE BE ADVISED THAT ALL CO-PAYMENTS ARE EXPECTED TO BE PAID AT THE TIME THE SERVICE IS RENDERED.**

AGREEMENT TO PAY LAKE CHAMPLAIN GYNECOLOGIC ONCOLOGY

Patient and/or guarantor (where applicable) agree that in consideration of the services to be rendered by Lake Champlain Gynecologic Oncology that the insured personally promises and obligates himself/ herself to pay the amount of Lake Champlain Gynecologic Oncology charges in accordance with its regular rates and terms. In the event of non-payment, patient and/or guarantor (where applicable) understand that such non-payment may be reported to a credit reporting agencies and agrees to pay all reasonable costs of collections including attorney's fees. Lake Champlain Gynecologic Oncology has the right to assess an interest rate monthly to all outstanding balancing over 3 months old. Lake Champlain Gynecologic Oncology is authorized to access credit bureau files and reports now and in the future for collection purposes. This information is given pursuant to Title 9 Sec. 2480E of Vermont Statues.

AUTHORIZATION OF MEDICARE BENEFITS

I request payment of authorized Medicare benefits To Lake Champlain Gynecologic Oncology on my behalf for services furnished to me by Lake Champlain Gynecologic Oncology. I authorized any holder of medical and other information about me be released to Medicare and its agents to help determine these benefits or benefits for related services.

SIGNATURE DATE WITNESS IF GUARANTOR HAS SIGNED

Lake Champlain Gynecologic Oncology

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I acknowledge that I have received and read a copy of the Lake Champlain Gynecologic Oncology's Notice of Privacy Practices. *Please ask front end staff if you would like another copy to review.*

Yes: ☐ No: ☐

LCGO PATIENT PORTAL AUTHORIZATION

PLEASE NOTE: *If you choose to utilize the secure patient portal all of your appointment reminders, medical information, lab results & billing/statements will be available through the secure patient portal. Once activated, you will receive a confidential username and password which will be sent to the email address provided below with instructions for signing on.* By agreeing to use the patient portal, you will be notified of test results via email rather than by phone.

Please indicate **how you would prefer us to contact you** regarding medical information:

Phone: ☐

OR

Patient Portal: ☐

Email Address: _____

Is this your email? Yes ____ No ____

If no, who does this email address belong to: _____

LCGO AUTHORIZATION FOR PROTECTED HEALTH INFORMATION

Please indicate whom (if anyone) we may contact or speak with regarding medical and/or billing information?

_____ _____
Person's Name Relationship to Patient

_____ _____
Person's Name Relationship to Patient

SIGNATURE DATE WITNESS IF GUARANTOR HAS SIGNED