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 ask you for any missing information.

# REGISTRATION FORM

LAST NAME____________________ FIRST NAME____________________

MAILING ADDRESS________________________________________

STREET ADDRESS________________________________________

CITY________________ STATE______________ ZIP______________

DATE OF BIRTH ____________________ SOCIAL SECURITY NUMBER____________________

RACE ______________ ETHNICITY______________ LANGUAGE______________

HOME#______________ CELL#______________ MARITAL STATUS______________

PHARMACY & ADDRESS ________________________________________

REFERRING PHYSICIAN______________________________ PHONE______________

PRIMARY PHYSICIAN______________________________ PHONE______________

EMERGENCY CONTACT & RELATIONSHIP____________________ PHONE______________

PHARMACY NAME & ADDRESS:________________________________________

## 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 LCGO, 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 at LCGO.

## CONSENT TO OBTAIN or RELEASE PATIENT INFORMATION

I HEREBY AUTHORIZE LCGO to **REQUEST** from any physician or physician group any medical information/records pertaining to my care. I ALSO HEREBY AUTHORIZE LCGO to **RELEASE** to any physician or physician group involved in my care any and 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 LCGO: or any governmental agency requesting information for lawful purposes.

________________________________________

NAME DATE WITNESS IF GUARANTOR HAS SIGNED

# 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 _______________________

## 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 CO., CHANGE OF ID. #, BILLING ADDRESS, ETC.) IT IS YOUR RESPONSIBILITY TO NOTIFY US OF THESE CHANGES AT THE TIME OF THEIR APPOINTMENT. IF CHARGES ARE INCURRED DUE TO ANY OF THE ABOVE REASONS, THE PATIENT WILL BE RESPONSIBLE AND BILLED DIRECTLY FOR THESE CHARGES.**

## 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. 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 insurance. **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 guarantor (where applicable) agree that in consideration of the services to be rendered by Lake Champlain Gynecologic Oncology reach 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 guarantor (where applicable) understand that such non-payment will be reported to credit reporting agencies and aggress to pay all reasonable costs of collections including attorney's fees. 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.

____________________________________________________________

NAME DATE WITNESS IF GUARANTOR HAS SIGNED

Lake Champlain
Gynecologic Oncology

# Authorization for Protected Health Information

## Please indicate how you would prefer us to contact you regarding the following information:

How would you prefer to be contacted for Appointment information or questions?

______________________________________________

How would you prefer to be contacted for Medical information or questions?

______________________________________________

How would you prefer to be contacted for Billing information or questions?

______________________________________________

**If you would like any of the above to be via email, please complete a patient portal form.**

## Please indicate whom (if anyone) we may contact or speak with regarding the following information:

Appointment information: ______________________________

Medical information: ______________________________

Billing information: ______________________________

______________________________ ______________________________
Signature of Patient/Guardian Date

4/3/12

# Authorization for Protected Health Information

## Patient Portal: Yes No

Once you are activated you will receive a confidential username and password which will be sent to the email address provided below.

**Please note:** If you choose to utilize the patient portal all of your appointment reminders will all be conveyed via email & all medical & billing information will require you to log into the patient portal for viewing utilizing your secure username and password.

**Email address** ______________________________ (*Please note an email address is required to utilize the patient portal*).

Is this your email address? Yes No

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

______________________________ ______________________________
Signature of Patient/Guardian Date

______________________________ ______________________________
Signature of Email Owner if not the patient Date

8/12/11

Lake Champlain
Gynecologic Oncology

1060 Hinesburg Rd South Burlington, VT 05304 Phone: 802-859-9500 Fax: 802-859-9944

**RECEIPT OF NOTICE OF PRIVACY PRACTICES**
**WRITTEN ACKNOWLEDGEMENT FORM**

I, ______________________________, have received a copy of the Lake
Patient Name

Champlain Gynecologic Oncology's Notice of Privacy Practices.

______________________ ______________________
Signature of Patient Date

Effective Date of this Notice: 4/14/03

Lake Champlain
Gynecologic Oncology, P.C.

Gamal H. Eltabbakh, MD, FRCOG, FACOG · 1060 Hinesburg Rd Suite 301 So. Burlington, VT 05403 · P: 802.859.9500 / F: 802.859.9944

NOTICE OF PRIVACY PRACTICES
As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE ) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.**

**PLEASE REVIEW THIS NOTICE CAREFULLY.**

## A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

**The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.**

## B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

**Privacy Officer: Lake Champlain Gynecologic Oncology**
1060 Hinesburg Rd Suite 301
**South Burlington, VT 05403. Phone (802) 859-9500**

if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to LCGO Privacy Officer, address as above, phone number (802) 859-9500. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact LCGO Privacy Officer, address as above, phone number (802) 859-9500.

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact LCGO Privacy Officer, address as above, phone number (802) 859-9500. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact:
Privacy Officer: Lake Champlain Gynecologic Oncology
1060 Hinesburg Rd, Suite 301
South Burlington, VT 05403. Phone (802) 859-9500

Effective Date of this Notice:_4/14/03__

## C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI 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. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. **Payment.** Our practice may use and disclose your IIHI 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), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations.** Our practice may use and disclose your IIHI 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 IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI 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 your IIHI 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 the pediatrician's office for treatment of a cold. 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 IIHI when we are required to do so by federal, state or local law.

## D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL 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 IIHI to public health authorities that are authorized by law to collect information for the purpose 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 or contracting 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); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful

**11. Inmates.** Our practice may disclose your IIHI 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.

**12. Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

## E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

**1. Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to LCGO Privacy Officer, address as above, phone number (802) 859-9500, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

**2. Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required** to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to LCGO Privacy Officer, address as above, phone number (802) 859-9500. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

**3. Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to LCGO Privacy Officer (address as above, phone number (802) 859-9500) in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

**4. Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to LCGO Privacy Officer, address as above, phone number (802) 859-9500. You must provide us with a reason that supports your request for amendment. Our practice will deny your request