



Lake Champlain Gynecologic Oncology

Please fill out this form completely and indicate with N/A where applicable. If not completed in its 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 _____

HOME# _____ CELL# _____ MARITAL STATUS _____

REFERRING PHYSICIAN _____ PHONE _____

PRIMARY PHYSICIAN _____ PHONE _____

EMERGENCY CONTACT & RELATIONSHIP _____ PHONE _____

PHARMACY NAME & ADDRESS: _____

EMPLOYER INFORMATION

COMPANY NAME _____ WORK PHONE _____ EXT _____

ADDRESS _____ CITY _____ ST. _____ ZIP _____

BILLING INFORMATION

IT IS YOUR RESPONSIBILITY TO SEE THAT REFERRALS ARE OBTAINED PRIOR TO YOUR APPOINTMENT IF ONE IS NEEDED IN ACCORDANCE WITH YOUR INSURANCE PLAN. IF THERE ARE ANY CHANGES RELATED TO YOUR INSURANCE INFORMATION (E. CHANGE OF ID #, ETC.) IT IS YOUR RESPONSIBILITY TO NOTIFY US OF THESE CHANGES AT THE TIME OF YOUR APPOINTMENT. IF CHARGES ARE INCURRED DUE TO THE ABOVE REASONS, YOU WILL BE BILLED DIRECTLY FOR THESE CHARGES.

PRIMARY INSURANCE INFORMATION

SUBSCRIBER NAME _____ RELATIONSHIP _____

DATE OF BIRTH OF SUBSCRIBER (if other than self) _____

INSURANCE _____ COPAY _____

ID# _____ GROUP # _____

SECONDARY INSURANCE INFORMATION

SUBSCRIBER NAME _____ RELATIONSHIP _____

DATE OF BIRTH OF SUBSCRIBER (if other than self) _____

INSURANCE _____ COPAY _____

ID# _____ GROUP # _____

*****PLEASE TURN OVER*****

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 FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE LCGO to request from any physician or physician group to release any medical information/records pertaining to my care. I ALSO HEREBY AUTHORIZE LCGO and any physician or physician group involved in my care to release 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.

AUTHORIZATION TO ASSIGN INSURANCE BENEFITS

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 LCGO. Patient agrees to sign any additional assignment of benefits form requested by LCGO or any insurance company from time to time. Patient understands that she is liable to LCGO 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.**

AUTHORIZATION OF MEDICARE BENEFITS

I request payment of authorized Medicare benefits to me or on my behalf for services furnished to me by LCGO. 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.

AGREEMENT TO PAY LCGO

Patient and guarantor (where applicable) agree that in consideration of the services to be rendered by LCGO, reach personally promises and obligates himself/herself to pay the amount of LCGO 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 agree to pay all reasonable costs of collections including attorney's fees. LCGO 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 Statutes.

I have reviewed both sides of this form and filled in all areas to the best of my ability leaving no fields blank.

NAME _____

DATE _____

WITNESS IF GUARANTOR HAS SIGNED _____