



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 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 (IE. 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.

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.**

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.

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.

NAME

DATE

WITNESS IF GUARANTOR HAS SIGNED



Lake Champlain Gynecologic Oncology

Authorization for Protected Health Information

If your preference for any of the below is via email, please provide your email address where indicated.

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?

Email address: _____

Patient Portal: Yes No

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

Appointment information: _____

Medical information: _____

Billing information: _____

Signature of Patient/Guardian _____ Date

