



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 agree 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 Statutes.

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



Lake Champlain Gynecologic Oncology

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

Name _____ MRN _____ DOB _____ Date _____

MENSES

Age at first period	
Last Menstrual Period	
From the first day of my period, to the first day of my next period, my menses occur every _____ days and last for _____ days.	

Check if you have any of the following:

<input type="checkbox"/>	Painful periods requiring more than Aspirin or Tylenol
<input type="checkbox"/>	Excessive bleeding
<input type="checkbox"/>	Irregular periods or bleeding
<input type="checkbox"/>	Bleeding more than 7 days
<input type="checkbox"/>	Spotting or bleeding between menses
<input type="checkbox"/>	Bleeding after intercourse
<input type="checkbox"/>	Symptoms that occur before your period that are annoying or bothersome for you now
<input type="checkbox"/>	Change in menstrual pattern: Describe:
<input type="checkbox"/>	If menopausal, any bleeding or spotting in the past year

GYNECOLOGY

Check if you have any of the following:

<input type="checkbox"/>	Unusual vaginal discharge/odor/irritation	<input type="checkbox"/>	Vulvar itching or irritation
<input type="checkbox"/>	Pain with intercourse	<input type="checkbox"/>	Pelvic pressure
<input type="checkbox"/>	Need to douche	<input type="checkbox"/>	Hot flashes
<input type="checkbox"/>	Menopausal symptoms	<input type="checkbox"/>	Bulging from the vagina
<input type="checkbox"/>	Loss of urine with cough or sneeze		
<input type="checkbox"/>	Uncontrollable loss of urine: _____ Mild _____ Moderate _____ Severe		
<input type="checkbox"/>	Unsatisfactory personal/sexual relationship		
<input type="checkbox"/>	History of sexual abuse. Have you talked to somebody about this?		
<input type="checkbox"/>	Concerns about sexually transmitted diseases (STD's)		
Do you have a current sex partner/s? YES NO How long have you been with this partner?			
My current method of birth control is:			

Check if you have ever had any of the following:

<input type="checkbox"/>	Abnormal pap smear	<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	Sexually transmitted disease (STD's)	<input type="checkbox"/>	Polycystic ovarian syndrome
<input type="checkbox"/>	Infection in your tube, ovaries, or uterus		

PREGNANCY HISTORY

List pregnancies in order (include abortions, prematures, etc.):					
MO/YR	HOSPITAL	WKS/MOS	WGT	SEX	COMPLICATIONS

Name _____ MRN _____ DOB _____ Date _____

OPERATIONS		
DATE	HOSPITAL	OPERATION

IMMUNIZATIONS			
Tetanus: Date:		Chicken Pox	
Hepatitis B Series		Rubella titer	
Have you ever had chicken pox or shingles?	YES	NO	Date: _____

SOCIAL HISTORY					
	Yes	No		Yes	No
Recreational Drugs			Domestic Violence		
Seat Belt Use			Balanced Diet		
Folic Acid Intake			Calcium Intake: _____ mg/day		
Caffeine Intake			Monthly Breast Self Exam		
Vitamins: _____ _____			Regular Exercise: <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Weight Bearing		
Tobacco Use: # of cigarettes _____ /day, for _____ years			Alcohol Use: # of glasses _____ /week		
Health hazard at home/work Occupation: _____			Cultural/Religious restrictions		

PERSONAL & FAMILY HISTORY		
Personal History- check here if <u>you</u> have the following:		Family History- check here if <u>blood relatives</u> have the following:
	High Blood Pressure	
	Heart Attacks	
	Diabetes	
	Thyroid Disease	
	High Cholesterol	
	Cancer	
	Bleeding Disorder	
	Hepatitis	
	Down Syndrome	
	Birth Defects	
	Sickle Cell Disease	
	Glaucoma/Blindness (prior to age 50)	

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date Completed: _____ Date of Birth: _____

Please mark below if there is a **personal or family history** of any of the following cancers. If yes, then indicate family relationship and **age at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	Age at Diagnosis	SIBLINGS/CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
For example: Colorectal cancer	<i>none</i>	<i>—</i>	<i>Brother</i>	<i>36 yrs</i>	<i>Aunt Cousin</i>	<i>44 yrs 58 yrs</i>	<i>Grandfather</i>	<i>65 yrs</i>

BREAST AND OVARIAN CANCER

Breast cancer

Ovarian cancer

Breast cancer in both breasts OR multiple primary breast cancers

Male breast cancer

Are you of Ashkenazi Jewish descent? Yes No

COLON AND UTERINE CANCER

Uterine (endometrial) cancer

Colorectal cancer

Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer

10 or more cumulative colon polyps

MELANOMA

Melanoma

Pancreatic cancer

OTHER CANCER

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HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER BEEN TESTED FOR HEREDITARY RISK OF CANCER?

Yes No If yes, please explain: _____

FOR OFFICE USE ONLY	
<input type="checkbox"/> Patient appropriate for further risk assessment and/or genetic testing <input type="checkbox"/> BRACAnalysis® – A test for Hereditary Breast and Ovarian Cancer Syndrome <input type="checkbox"/> COLARIS® – A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer) <input type="checkbox"/> COLARIS AP® – A test for Adenomatous Polyposis Syndromes <input type="checkbox"/> MELARIS® – A test for Hereditary Melanoma	<input type="checkbox"/> Discussed hereditary cancer risk with patient <input type="checkbox"/> Patient offered genetic testing <input type="checkbox"/> ACCEPTED <input type="checkbox"/> DECLINED <input type="checkbox"/> Follow up appointment scheduled Date: _____

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



Lake Champlain
Gynecologic Oncology, P.C.

Effective Date of this Notice: 4/14/03

Gamal H. Elzabbach, MD, FRCOG, FACOG ¹⁰⁶⁰ Hinesburg Rd Suite 301, 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

Effective Date of this Notice: 4/14/03

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

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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.

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6. **Health-Related Benefits and Services.** Our practice may use and disclose your PHI 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 PHI 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 PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI 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 PHI 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 PHI 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 PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful

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11. **Inmates.** Our practice may disclose your IIIH 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 IIIH for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIIH

You have the following rights regarding the IIIH 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 IIIH for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIIH 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 IIIH, 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 IIIH 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 IIIH. 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