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