Lake Champlain
OB/GYN

Welcome to our practice!

We look forward to developing an on-going relationship with you. Our goal is to provide excellent Gynecologic services for women of all ages, in a friendly and relaxed environment.

To expedite your first visit, we ask that you complete the "**New Patient Paperwork**" and return it to us by mail or fax it to 518.566. 9831. We require the patient information be entered in our Electronic Health Record **prior** to scheduling an appointment unless you are referred by another physician as an emergency.

To expedite your first visit, please bring

- your **insurance card** and **driver's license** (or valid photo ID);
  It is our policy to require payment in full at the time of your first visit if you do not provide us with your insurance card and driver's license (or a valid photo ID). We accept Visa, MasterCard and American Express
- any copay amount specified on your insurance card;
- your current medication list, and
- pharmacy name and address.

Due to HIPAA regulations, we are required to ask a series of privacy questions for your medical record and to take your photo for your electronic health file in an effort to protect you from identity theft and insurance fraud.

Our office hours are 8:00 a.m. to 4:30 p.m., Monday through Friday. After hours, weekends and holidays our "on-call" provider can be reached for emergencies by calling 518-566-9452. For additional information on our Practice, please visit our website at: http:// www.lakechamplainobgyn.com.

Please let us know if there is anything we can do to accommodate your needs and make your experience as pleasant as possible.

We look forward to meeting you,

The doctors and staff at Lake Champlain OB-GYN

46 Broad Street · Plattsburgh, New York 12901
Telephone 518-566-9452 · Fax 518-566.9831 · www.lakechamplainobgyn.com

Lake Champlain Ob-Gyn, P.C.

NEW PATIENT QUESTIONNAIRE - WELCOME TO OUR PRACTICE!!

Patient's Name_____
First Name *Middle Initial* *Last Name*

Maiden Name_____ Date of Birth_____/_____/_____ Religion_____

Martial Status: *S / M / D / W / SEP. / LEG. SEP.* Years Married_____ Highest Level of Education_____

Social Security #_____ Email Address_____

Present Address_____
Street *City/State* *Zip Code*

Home Phone #( )_____ Cell Phone#( )_____ Work #( )_____

Patient's Place of Employment_____

Husband's or Domestic Partner's Name_____
First Name *Middle Initial* *Last Name*

Husband 's or Domestic Partner's Place of Employment_____

* Primary Insurance_____

ID#_____ Group#_____ Policy Holder_____

Policy Holder's Date of Birth_____ SS#_____ Relationship to Patient_____

* Secondary Insurance_____

ID#_____ Group#_____ Policy Holder_____

Policy Holder's Date of Birth_____ SS#_____ Relationship to Patient_____

Nearest Relative (MUST ANSWER THIS QUESTION)

Name_____ Address_____

Relationship_____ Home#_____ Cell#_____ Work#_____

Your Signature_____ Date_____

******WE WILL NEED A COPY OF YOUR INSURANCE CARDS...PLEASE BRING WITH YOU******

Lake Champlain Ob/Gyn, P.C.
46 Broad Street, Suite A, Plattsburgh, NY 12901

SELF HISTORY

Please fill out as accurately as possible: Today's Date_____

Name_____ Date of Birth_____

Race_____ Are you of Hispanic or Spanish origin_____ Primary Language_____
(Government required question)

Primary Care Doctor_____ Phone Number_____

Please **list** all medications, supplements and/or vitamins you are **currently** taking:

Medications	Dosage	Times Per Day

Drug Allergies_____

Other Allergies_____

Are you experiencing any of the following ? (Please circle)

Weight Loss/Gain	Nausea/Vomiting	Leakage of Urine
Skin Problems	Change in Bowel Habits	Painful Urination
Cough/Cold Symptoms	Blood in Stool	Depression/Anxiety
Shortness of Breath	Abdominal Bloating	Suicidal Thoughts
Chest Pain	Vaginal Dryness	Violence in your Home

SOCIAL HISTORY

Occupation_____Employer_____
Are you: Married_____ Single_____ Widowed_____ Divorced_____
Do you or have you ever smoked_____If yes, how much per day_____ If quit, when_____
Recreational drug use_____ What type_____ How often_____
Alcohol use: Occasional/Social_____If daily,how much_____Never_____
Have you been or are you currently in recovery for drug/alcohol dependency_____
Do you exercise_____ What type/how often_____

GYNECOLOGIC HISTORY

If menopausal, age of menopause_____ (If yes, please skip the next questions)
First day of last menstrual period_____ Age of first menstrual period_____
How many days between periods_____How many days do your periods last_____
Do you have cramps with your periods_____ Severity of cramps_____
Have you received the HPV vaccine (Gardasil) Yes _____ No_____ If no, are you interested in information about and/or receiving (Gardasil) Yes _____ No_____
Any history of abnormal Pap smears: If yes, when_____
Treatments (Repap, Colposcopy, LEEP)_____

Date of last Mammogram_____Date of last Bone Mineral Density Test_____

SEXUAL HISTORY

Age of first sexual intercourse_____ Total number of partners in lifetime_____
Are you sexually active____ Current sexual partner(s) is /are: Male____ Female_____Both_____
Past sexual partners: Male____ Female_____ Both _____
Have you ever had a sexually transmitted disease_____ HIV_____ Trichomonas_____
Gonorrhea_____ Chlamydia_____Herpes_____HPV_____Syphilis_____ Other_____
Any history of sexual abuse:_____

CONTRACEPTION

What is your current birth control method_____
Are you interested in a different type of birth control_____
What forms of birth control have you used in the **past** and **did not** tolerate_____
_____

PREGNANCY HISTORY

Number of Pregnancies_____Number of Living Children_____Do you plan to become pregnant in the future?_____

Date	Type of delivery: vaginal, c/section, miscarriage, ectopic or abortion	Weeks/ Gestation	Name of Infant	Sex M or F	Weight of Infant	Hrs in labor	Complications (Please describe)

FAMILY HISTORY - Please complete this chart to the best of your ability giving as much detail as possible. ***You only need to fill in the boxes that pertain to your family.***

	Mother	Father	Sister(s)	Brother(s)	Mother's Mother	Mother's Father	Father's Mother	Father's Father	Other Relative (list)
Alive&Well Age									
Age of Death (Reason)									
Diabetes									
High Blood Pressure									
High Cholesterol									
Heart Disease									
Cancer-Ovarian									
Cancer-Breast									
Cancer-Uterus									
Cancer-Colon									
Cancer-Other Describe									
Genetic Disorders									
Strokes									
Other Medical Problems									

Have you had a screening Colonoscopy: Yes_____ No_____If yes, When_____

SAFETY

Do you have adequate food : Yes_____ No_____ Shelter: Yes_____ No_____
Do you feel safe in your current environment: Yes_____ No_____
If no, please explain:_____
_____
Any current or past history of physical, emotional, or psychological abuse: Yes_____ No_____
If yes, please explain:_____
_____

*Signature*_____ *Date*_____

PERSONAL MEDICAL PROBLEMS (please check all that apply)

	Yes	Past or Present (please explain)
Headaches (including migraines)		
Thyroid Problems		
Asthma		
TB (Tuberculosis)		
Rheumatic Fever		
Heart Disease		
High Cholesterol		
High Blood Pressure		
Epilepsy/Seizures		
Anemia		
Blood Transfusion		
Breast Lumps		
Liver Disease		
Mononucleosis		
Gallbladder		
Stomach		
Intestinal		
Kidney/Bladder		
Varicose Veins/Phlebitis (DVT/PE)		
Diabetes		
Cancer (What Type)		
Weight Problems		
Uterus/Ovaries/Tubes		
Osteoporosis/Osteopenia/Broken Bones		
Genetic Problem		
Eating Disorder		
Depression/Anxiety		
Attention Deficit Disorder (Child/Adult)		
Bipolar		
Other		

CHILDHOOD ILLNESS (please check all that you have had)

Chicken Pox_____ Measles_____ Mumps_____ Other_____

SURGICAL HISTORY

Date of Surgery	Type of Surgery	Physician

PERSONAL HISTORY INFORMATION(PHI)/AUTHORIZATION FORM

By signing this form, I am consenting to Lake Champlain Ob/Gyn, P.C.'s use and disclosure of my PHI to carry out payment and healthcare operations (TPO).
By signing below I also acknowledge that I have received the Notice of Privacy Practices and I have been provided an opportunity to review it or keep it for future reference.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, Lake Champlain Ob/Gyn, P.C. may decline to provide treatment to me.**

_____

Patient's Name (Print)

_____

Signature of Patient or Legal Guardian *Date*

_____

Name of Legal Guardian (Print)

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Lake Champlain Ob/Gyn P.C. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign the providers for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

*Signature*_____

SPECIAL CONSENT FOR MINORS AND STUDENTS ONLY:

WE CANNOT DISCUSS ANY MEDICAL INFORMATION WITHOUT YOUR WRITTEN CONSENT. I GIVE MY PERMISSION TO LAKE CHAMPLAIN OB/GYN, P.C. PROVIDERS AND OFFICE STAFF TO RELEASE INFORMATION FROM MY MEDICAL RECORDS TO:

_____ _____

Name *Relationship*

_____ _____

Name *Relationship*

Does this permission include <u>ALL</u> information in your chart? Yes_____ No_____

IF NOT: Please specify what you would like to keep confidential, and information not to be released:_____

_____

*Signature*_____ *Date*_____

PATIENT FINANCIAL POLICY FOR LAKE CHAMPLAIN OB/GYN, P.C.

*Patient's Name*_____ *Date of Birth*_____

COMMERICAL INSURANCE CARRIERS: We participate with most major insurance companies and we will bill most insurance carriers for you if proper information is provided to us. Any outstanding balances ,co-payments and deductibles are due to prior checking in for your appointments. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you.

MEDICARE: Our office is a Medicare participating provider and we will bill Medicare for you. We will bill your secondary insurances that automatically cross-cover through the CMS (Medicare System). If your secondary insurance does not cross-cover, we will send one courtesy form to the carrier. Any outstanding balances and deductibles are due prior to your appointments. Any co-insurance and non covered services will be due as the service is rendered. We ask our Medicare patients to sign an ABN (Advanced Beneficiary Notice) prior to being seen. This for must be signed by the patient at each visit. Please read the form carefully prior to signing. Any questions regarding this can be addressed by our billing department staff.

MEDICAID: Our office is a Medicaid participating provider and we will bill Medicaid for you. Any outstanding balances, co-payments and deductibles are due prior to your appointments. It is your responsibility to bring an active Medicaid card with you to be presented at ***each*** visit.

WORKERS COMPENSATION: If your visit is work related, we will need the case number carrier information prior to your visit in order to bill the Worker's Compensation company.

NO-FAULT (AUTOMOBILE ACCIDENT): If your visit is related to an injury received in a No-Fault related accident, we will need the claim number and complete insurance company information prior to your visit in order to bill the No-Fault carrier.

MISSED APPOINTMENTS: ***We request a 24 hour*** notice if you are unable to keep a scheduled appointment. There will be a **$25.00 charge** assessed to your account if you fail to show and do not notify us in advance.

METHODS OF PAYMENT:
Our office accepts the following payment options:
Cash, personal checks, credit/debit cards, and patient financing options for those patients who are credit worthy.

FINANCIAL TERMS:
For returned checks, we assess a **NSF fee charge**. A report will be sent to the local District Attorney's Office for checks that are not paid within 2 weeks of being returned to our office. We participate with the Clinton County Check Enforcement Program.

Any personal balance overdue more than **60** days will be assessed a 1.5% finance charge per month.

If your account is not paid according to these terms you understand that our office reports to an outside collection agency. In the event that your account is turned over to the collection agency, all additional fees assessed in the collection of the debt including finance charges and legal fees will be forwarded to the collection agency. In addition, we reserve the right to discharge you from our practice if payment terms are not met. If this occurs you will receive a certified letter and we will provide 30 days emergency care. Your medical records will be sent to another provider of your choice.

You are responsible for all fees incurred at the time services are rendered. You are required to present a valid insurance card at ***every visit*** and as needed throughout your care. I have read, understood and agreed to the above financial policy for payment of professional fees.

*Signature*_____ *Date*_____

CONSENT TO ROUTINE PROCEDURES & TREATMENTS

During the course of my care and treatment, I understand that various types of tests and diagnostic procedures may be necessary. These procedures may be performed by physicians, nurse practitioners, nurse midwives, nurses and medical assistants.

While routinely performed without incident, there may be material risks associated with each of these procedures. I understand that it is not possible to list every risk for every procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the procedures.

The procedures may include, but are not limited to the following:

1. **Physical tests** such as vital signs, internal body examinations, wound cleansing, wound dressing, and other similar procedures. The material risks associated with these types of procedures include, but are not limited to allergic reactions, infection, loss of blood, nerve damage, disfiguring scar or worsening of the condition.

2. **Drawing blood, bodily fluids or tissue samples** such as that done for laboratory testing and analysis. The material risks associated with this type of procedure include but are not limited to internal injuries, bleeding, and infection. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.

3. **Insertion of internal tubes** such as bladder catherization. The material risks associated with these types of procedures include but are not limited to internal injuries, infection, loss of bladder control and/or difficulty urinating after catheter is removed. Apart from external collection devices or refusal of treatment, no practical alternatives exist.

4. **Needle sticks** such as injections or intravenous lines. The material risks associated with these types of procedures include but are not limited to, nerve damage, infection, infiltration (fluid leakage into surrounding tissue), or disfiguring scar. Alternatives to needle sticks include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.

I UNDERSTAND THAT:

The practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the outcome and/or result of any procedures. The healthcare professionals participating in my care will rely on my documented medical history as well as information obtained from me, my family, or others having knowledge about me, in determining whether to perform or recommend the procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions.

BY SIGNING THIS FORM:

I consent to healthcare professionals performing procedures as they may deem reasonably necessary or desirable for the exercise of their professional judgment **including procedures that may be unforeseen or not known to be needed at the time this consent is obtained;** and I acknowledge that I have been informed in general terms of the nature and purpose of the procedures; the material risks of the procedures; and practical alternatives to the procedures. If I have any questions or concerns regarding these procedures, I will ask my Physician, Nurse Practitioner or Nurse Midwife to provide me with additional information. I understand that I may be asked to sign additional consent documents.

*Signature of Patient (or authorized person)*_____

Name of Patient (print) _____ *Date*_____

*Reason patient is unable to sign*_____

LAKE CHAMPLAIN OB/GYN, PC
46 Broad Street, Suite A,
Plattsburgh, NY 12901
Phone: 518.566.9452 Fax: 518.566.9831

APPOINTMENT CANCELLATION, NO SHOW, AND LATE ARRIVAL POLICY

Lake Champlain Ob/Gyn is committed to providing the highest quality care to our patients. Our staff works hard to schedule you an appointment with a convenient time.

- Scheduled appointments ***not*** cancelled 24-hours prior to your appointment time may be subject to a **$25 fee**, and considered a ***no-show*** visit.
- All patients are asked to arrive ***15 minutes prior*** to their appointment time. If you arrive past your scheduled appointment time, you will be rescheduled and may be subject to a ***$25 fee.***
- **If you have three (3) or more no-show appointments, you may be DISCHARGED from the practice.**

No-show or missed appointments have a great impact on our ability to provide timely access to care. When a person fails to show for a scheduled appointment or fails to give a 24-hour notice, it leaves empty time in our provider's schedule that could have been utilized by a patient in need.

If you have any questions regarding this policy, please let our staff know and we will be glad to speak with you in more detail. We thank you in advance for your cooperation and understanding. By signing below, you acknowledge that you have been presented with the above policy.

_____
Printed Name and Date of Birth of Patient

X _____ _____
Signature of Patient / Parent / Guardian or Authorized Representative Date

_____ _____
Printed Name of Parent / Guardian or Authorized Representative Relationship to Patient

Updated 1/29/2019

LAKE CHAMPLAIN OB/GYN, PC

46 Broad Street, Suite A, Plattsburgh, NY 12901
Phone: 518.566.9452 Fax: 518.566.9831

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
Consent for Use or Disclosure of Protected Health Information

Patient Name	Date of Birth	Phone
Patient Address	City	State, Zip Code

I authorize

Lake Champlain Ob/Gyn, PC
46 Broad Street, Suite A, Plattsburgh, NY 12901

☐ RELEASE Information TO or ☐ OBTAIN Information FROM

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: _____ Phone: _____

Address: _____ City: _____ State, Zip Code: _____

Place an "X" in the box(es) that apply to the information you want released or you want to obtain.

☐ Annual Exam Notes ☐ GYN Exam Notes / Assessments ☐ Prenatal Records ☐ Diagnostic / Lab Results ☐ Operative Reports

☐ Medical Records from (insert date) _____ to (insert date) _____

☐ Other _____

Purpose of Disclosure: ☐ Change of Insurance or Physician ☐ Continuation of Care ☐ Legal Services ☐ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
2. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
3. Information disclosed under this authorization might be redisclosed by the recipient and this redisclosure may no longer be protected by federal or state law.

Expiration: This authorization becomes effective immediately and shall expire on:_____. If no date is given, this authorization is valid for **12 months** from signature date.

In order to better serve our patients, your feedback is appreciated.

☐ **I am not** transferring my care to this physician/facility on a permanent basis.
☐ I am leaving Lake Champlain Ob/Gyn and transferring my care to this physician/facility permanently.
Reason for transferring from practice: ☐ Moving ☐ Insurance ☐ Dissatisfied ☐ Other _____

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

_____ _____

Printed Name of Authorized Representative

Relationship / Capacity to Patient