



Thank you for choosing Lake Champlain Ob/Gyn, P.C. and Lake Champlain Midwifery Services.

In order to expedite your first visit, we ask that you please fill out the enclosed forms and return them to us **as soon as possible** by *fax to 518-324-5811, or you may email the forms to lakeobgyn@primelink1.net*. We require this information be entered into our Electronic Medical Records system **prior** to you scheduling an appointment unless you are referred by another physician as an emergency,

We ask that you arrive 15 minutes before your scheduled appointment time to allow for the check-in process. We will need you to bring your current insurance card, a form of photo identification, your current medication list and the name and address of your pharmacy. Also, 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 file in an effort to protect you from identity theft and insurance fraud.

If you cannot make your appointment at the scheduled time, please call our office at least 24 hours in advance to reschedule. If you fail to show up for your appointment we do charge a \$25.00 fee which cannot be billed to your insurance.

Our regular office hours are Monday through Friday 8:00 AM-4:45 PM. After hours, on weekends and on holidays our “on-call” provider can be reached for emergencies by contacting our answering service at 518-566-9452. We do have a cross coverage agreement with one other Ob/Gyn practice to cover our patients 24 hours a day, 7 days a week, 365 days a year.

Please remember to return your completed paperwork as soon as possible. Thank you for allowing us to participate in your healthcare and we look forward to meeting you.

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

Marital 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******

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 _____

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 _____

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 form 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 catheterization. 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. P.C.- January 2013)

LAKE CHAMPLAIN OB/GYN, PC
206 Cornelia St., Ste. 306, Plattsburgh, NY 12901
Phone: 518.566.9452 Fax: 518.562.7189

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.
- If you are an established patient and you arrive **15 minutes late** to your appointment, you are considered a **no-show**, subject to a **\$25 fee**. You will likely be asked to reschedule unless the provider’s schedule can still accommodate you. Priority will be given to patients who arrive on time.
- If you are a **new** patient who is a **no-show** or arrives **15 minutes late** to your appointment, you **will not** be rescheduled.
- **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, arrives 15 minutes late, 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