



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 518.324.5811. 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*

Medical Office Building · 206 Cornelia Street, Suite 306 · Plattsburgh, New York 12901-2789  
46 Broad Street · Plattsburgh, New York 12901-2789  
Telephone 518-566-9452 · Fax 518-562-7189 · [www.lakechamplainobgyn.com](http://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 \_\_\_\_\_

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 \_\_\_\_\_

**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



**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.
- 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