CHAMPLAIN
GYNECOLOGY
Experienced, comprehensive & compassionate care that puts you first

Maria G. Carracino, MD, Anne Dougherty, MD,
Kara A. Flaherty, MD & John J. Gallagher, MD
Phone: 802-879-1802 ♦ Fax: 802-878-6131
Website: www.champlainobgyn.com

PAYMENT IS YOUR RESPONSIBILITY A copy of our complete payment policy can be found on our website or in our office.

Other IMPORTANT highlights and/or additions regarding our patient payment policy of which you MUST be aware:
-Any co-pays are due at the time of visit.
-If you have a deductible or co-insurance based plan, we may also collect a portion of today's fees at your visit.
-It is your responsibility to understand what your plan does/does not cover for services and procedures. We recommend treatment based on nationally recognized guidelines, not on individual insurance coverage.
-If you are unsure and concerned over whether a service will be covered, we will do our best to assist in that research, however, you must ask for assistance at least one week prior to the service being rendered.
-We have a less than twenty-four hour cancellation, change, or no-show policy. You may be charged $100 if we do not receive sufficient notice of cancellation, change, or no-show.

I HAVE READ THE ABOVE INFORMATION AS WELL AS THE PATIENT PAYMENT POLICY AND WELCOME LETTER AND UNDERSTAND MY RESPONSIBILITY.

Signature:_____ Date:_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of surgical and/or medical benefits to Champlain Gynecology, P.C., and further convey, transfer, and assign all of my rights in my insurance coverage to Champlain Gynecology, P.C., for service rendered. I also hereby assign and transfer any and all rights, title, and interest to any claim for penalties and/or attorney fees arising under and state or federal law or regulation relating to the payment of any claim for benefits to Champlain Gynecology, P.C. Regardless of the extent of the insurance coverage, I agree to be responsible for the entire balance. I also authorize release of information pertaining to my claim to my insurance company and/or companies or my attorney. Once the physician has obtained the patient's lifetime authorization, they may submit any later claim on either an assigned or unassigned basis without obtaining any additional signature from the patient. In submitting a claim, they should indicate "Signature on File".

Also, if I am a Medicare beneficiary, I certify that the information given by me in applying for a payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf once the physician has obtained the patient's lifetime authorization, they may submit any later Medicare claim on either an assigned or unassigned basis without obtaining any additional signature from the patient in submitting claim, they should indicate "Signature on File."

I HAVE READ THE ASSIGNMENT OF INSURANCE BENEFITS AND UNDERSTAND MY RESPONSIBILITY.

Signature:_____Date:_____

PATIENT CONSENT FORM

The following are IMPORTANT highlights and/or additions regarding our HIPAA Notice of Privacy Practices, of which you MUST be aware:
-When it is appropriate and necessary, we provide necessary information to third parties (i.e. physicians, insurance).
-We will not communicate directly with parents about any aspect of their child's healthcare (excluding payment). If you would like us to communicate with your parents in regards to your care, you must sign consent in front of one of our staff members
-With your signature below, you are also giving us permission to electronically retrieve your prescription record from the state of Vermont or your pharmacy.
-With your signature below, you are also authorizing us to access your medical information from UVMMC's electronic health record AND statewide electronic health record (VITL).

I HAVE READ THE ABOVE INFORMATION AS WELL AS THE HIPAA NOTICE OF PRIVACY PRACTICES AND UNDERTAND MY RIGHTS AND RESPONSIBILITIES.

Printed Name:_____Relationship to Patient:_____

Signature:_____Date:_____