Vermont Gynecology

PATIENT INFORMATION FORM

❑ UPDATE

Full legal name: _____ **Date of Birth:** __ __ / __ __ / _____
FIRST MIDDLE LAST

Preferred/Chosen Name: _____ Previous Names: _____

Pronouns: ❑ she/her ❑ he/him ❑ they/them ❑ ze/zir ❑ other _____ Social Security #: _____-_____-_____

Address:

_____
STREET ADDRESS TOWN STATE ZIP

Mailing Address (if different than above)**:**

_____
STREET ADDRESS AND/OR PO BOX TOWN STATE ZIP

Phone Numbers:

Cell: _____ Landline: _____

Work: _____ Other: _____

Where may we leave a **confidential** message? ❑ Cell ❑ Landline

Emergency Contact (required):

Name: _____

Relationship to you: _____

Phone: (_____)_____

Email address if you wish to join the **Patient Portal**: _____

We have your permission to discuss your care/results with:

(1) Name/phone _____

(2) Name/phone _____

Primary Care Provider: _____ Phone: _____

Facility name/Town/State: _____ Fax: _____

Pharmacy: _____ **Pharmacy Address/Town/City**: _____

Demographics: (Note: Some medical conditions are more common in certain groups. The following may be helpful in your care.)

Sex assigned at birth: ❑Male ❑Female ❑Decline to answer

Gender: ❑Male ❑Female ❑Trans man/FTM ❑Trans woman/MTF ❑Nonbinary ❑Other: _____ ❑Decline to answer

Relationship status (✓all that apply): ❑Single ❑Married ❑Civil Union ❑Partnered ❑Separated ❑Divorced ❑Widowed

Primary language: ❑English ❑Spanish ❑French ❑Chinese ❑Japanese ❑Hindi ❑ Tamil ❑Russian
❑Bosnian ❑Serbo-Croatian ❑Vietnamese ❑Bantu ❑Other: _____ ❑Language interpretation services needed?

Race (✓all that apply): ❑American Indian or Alaskan Native ❑Asian ❑Black or African American
❑Native Hawaiian or other Pacific Islander ❑White ❑Other race: _____ ❑Decline to answer

Ethnicity: ❑Hispanic/Latino ❑Not Hispanic/Latino ❑Decline to answer

If you are using your insurance today:

Please give your insurance card to the person at the front desk. If you choose to bill insurance for which you are not the primary subscriber, the policyholder may receive mail from the insurance company detailing where you received health care and the nature of the care.

Name of Insurance Company: _____ **Subscriber/Member ID#** _____

Insurance Subscriber:_____ **Date of Birth:** __ __ / __ __ / _____ **Relationship:** _____

Please read the following and sign below.

VTGyn may release any medical information and/or medical records needed by my health insurance company for determining benefits or paying claims. Payments from my health insurance company will be made directly to VTGyn. I understand that I am responsible to pay any deductibles, co-payments, or co-insurances for services not covered by insurance.

_____ _____
SIGNATURE DATE

FOR OFFICE USE ONLY: Date _____ **Initials** _____ **Patient #** _____

Vermont Gynecology

REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES AND CONSENT TO DISCLOSURES

TODAY'S DATE: _____ **PATIENT PHONE #** _____

PATIENT NAME (please print): _____ **DOB:** _____

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Vermont Gynecology may need to refer me to another health care facility to provide the services necessary for my care.

I will be given information about the test(s), treatment(s), procedure(s), and contraceptive method(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand, and that a clinician is available to answer any questions I may have.

No guarantee has been or will be given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Vermont Gynecology.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I will have lab tests such as Pap smears, biopsies, and blood and urine tests as indicated in my care. I understand that Vermont Gynecology will bill me for the procedures that generate the tests, as well as for any tests processed on site. I am aware that most specimens are sent to outside laboratories; that those labs set the fees for such tests; and that I will receive separate bills from those outside labs. I will assume responsibility for paying for these tests.

I understand that, if I have health insurance, I am responsible to pay for whatever my insurance does not cover, at their contracted rates. It is also my responsibility to understand what my insurance plan covers, as plans vary significantly.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in Vermont Gynecology's *Notice of Health Information Privacy Practices*. I consent to and authorize the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.

I hereby request that a person or persons authorized by Vermont Gynecology provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

I hereby acknowledge receipt of Vermont Gynecology's *Notice of Health Information Privacy Practices*.

Signature of patient _____ Date _____

Patient name (please print) _____

I witness that the patient received the above-mentioned information, voiced understanding and had the opportunity to ask questions.

Signature of witness _____ Date _____

❑ **CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW**

Signature of any other person consenting _____ Date _____

Relationship to patient _____

I witness the fact that the patient's legal guardian (or person consenting on the patient's behalf) received the above-mentioned information and said she read and understood the same.

Signature of witness _____ Date _____