VERIFIED:_____ DATE:_____

Lane OB/GYN
Care You Can Count On

**PATIENT INFORMATION**

ALLERGIES _____
LAST NAME _____
FIRST NAME _____
ADDRESS _____
CITY, STATE, ZIP _____
EMPLOYER _____
FULL TIME STUDENT? _____YES _____NO
SCHOOL ATTENDING _____
SPOUSE _____
PATIENT EMAIL _____
PATIENT HAS A LIVING WILL? _____YES _____NO

DATE OF BIRTH _____
HOME PHONE _____
CELL PHONE _____
SOCIAL SECURITY # _____
DRIVER'S LICENSE #_____

SPOUSE'S DOB _____

RESPONSIBLE PARTY INFORMATION
LAST NAME _____
FIRST NAME _____
ADDRESS _____
CITY, STATE, ZIP _____
EMPLOYER_____
FULL TIME STUDENT? _____YES _____NO
SCHOOL ATTENDING _____
SPOUSE _____

DRIVER'S LICENSE #_____
HOME PHONE _____
WORK PHONE _____
DATE OF BIRTH _____
SOCIAL SECURITY #_____

INSURANCE INFORMATION
INSURANCE NAME _____
GROUP # _____
ADDRESS _____
CITY, STATE, ZIP _____
PHONE # _____
INSURED'S DOB _____
PATIENT RELATIONSHIP TO INSURED:
_____SELF _____SPOUSE _____ CHILD

INSURED'S NAME_____
POLICY # _____

INSURED'S SSN _____

*IF YOU HAVE MORE THAN ONE INSURANCE, PLEASE ALLOW THE RECEPTIONIST TO COPY ALL OF THE CARDS.*

EMERGENCY CONTACT INFORMATION
NAME _____
PHONE _____

RELATIONSHIP _____
CITY _____

PLEASE READ AND SIGN
I understand that all services are charged to the patient, and as the patient, I am responsible for all charges not paid by my insurance. I hereby authorize Lane OB/GYN to obtain my medication history by means of electronic access which becomes part of my permanent record. I hereby indemnify the physician office and its agents from any and all responsibility relative to obtaining such information. I agree to pay all co-pays and uninsured charges at the time of service, unless arrangements have been made in advance. I authorize Lane OB/GYN to release my medical and financial information to my insurance carriers as necessary to receive payment. If I have no insurance, full payment is made at time of service.

_____ _____
DATE SIGNATURE

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Dear Patient,

Welcome to Lane OB/GYN. We are pleased that you have selected our office for your OB/GYN services. Please take the time to thoroughly read the following policies.

**Cancellation/Missed Appointments**
We request that if you are unable to make your scheduled appointment time that you extend the courtesy of notifying our office no later than 24 hours prior to your appointment. Our Doctors have reserved that time to provide you personalized quality care. If you cancel an appointment within 24 hours or do not show for your scheduled appointment, you may incur a fee of $50. Please note, this fee is not covered by your insurance carrier and will be your responsibility. If you miss more than two appointments without calling our office, our policy is to discharge your from care with Lane OB/GYN.

**Appointments**
We will make our best effort to honor your scheduled appointment time. However, there may be unforeseen delays due to surgeries, deliveries, and emergencies at the hospital. We hope that you understand that this may occur and we will notify you so that you can make the decision to wait or to reschedule if you are unable to wait.

**Insurance Filing**
As a courtesy, we will file your insurance claims to your carrier. We accept most major medical plans. Please check with the billing department if you have any questions. Please be aware that it is your responsibility to know your benefit coverage. Your insurance may not pay for all the services provided at Lane OB/GYN and you will be responsible for the services not paid by your carrier.

**Payments**
Copayments and coinsurance payments are expected at the time of service. This is the amount of the charges that your insurance carrier has determined to be your responsibility for your visit. Lane OB/GYN accepts cash, check, Mastercard, and Visa payments. We do not accept post-dated checks for payment. If you do not have insurance, payment in full is expected at the time of service. Also note that you will receive a separate bill from the lab company if any tests are performed.

**Prescription Refill Requests**
If you need a prescription refill, please have your pharmacy fax our office a request at 225-658-1304. Refill requests will be accepted Monday through Thursday, 8:00 a.m. to 4:00 p.m. We do not call in any medication after hours as the physician does not have access to your medical records during this time.

**Patient Inquiries**
If you have a non-emergent issue during regular business hours, you can leave a message for one of the Doctors with the appointment desk. Your call will be returned at the end of the business day.

**After Hours and Emergency Problems**
In the event of a true emergency, please dial 911 or go to the nearest Emergency Room. If there is a serious concern or issue that cannot wait until regular business hours, you may call 225-658-4545 and the OB/GYN on call will be notified. We ask that you only utilize these services when there is a true urgent or emergent situation.

**Please sign and date below to acknowledge that you have read and agree to the above policies.**

_____ _____

Signature Date

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**PATIENT AUTHORIZATION FORM**
**To request Health Information**

Patient Name: _____

Date of Birth: _____ Social Security #: _____

By signing this form I authorize _____ to disclose to
(name of physician or clinic)

Lane OB/GYN
6550 Main Street, Suite 2000
Zachary, LA 70791
Fax 225-658-1304

The following protected health information:

_____
(entire medical record, lab reports, X-rays, ER report, etc.)

The purpose of this disclosure is for
GYN/OB TREATMENT

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification. I understand that a revocation is not effective to the extent that information has already been used or disclosed in reliance on this authorization.

Lane OB/GYN will not deny my treatment or payment for my treatment on whether I provide authorization for the requested use or disclosure unless health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by Federal or State law.

This authorization will expire one year after the date listed below.

_____ _____
Patient or Legal Guardian's Signature Date

_____Dr. Best _____Dr. Bland _____Dr. Elbourne _____Dr. Gautreaux _____Paige Pedersen Muller, FNP-C

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**CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

**I understand that this information serves as:**

- A basis for planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

**I understand that I have the right:**

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I have been presented with a copy of this provider's **Notice of Privacy Policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my medical information:

_____

_____

_____

If you wish for other person(s) to have access to your health information, please list them here:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Lane OB/GYN
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Keith Elbourne, MD * Joshua Best, MD * Nikki Gautreaux, MD * Samantha Bland, MD * Paige Pedersen Muller, FNP-C
6550 Main Street, Suite 2000 * Zachary, LA 70791 * Phone # (225) 658-1303 * Fax # (225) 658-1304

NAME _____ DATE OF BIRTH _____

The start of my last menstrual cycle was _____. I have cycles every _____ days.

My cycle normally lasts _____ days. I would characterize my cycle as (circle one) light, normal, or heavy.

**Please list all pregnancies. Include miscarriages, abortions, and tubal pregnancies.**

| Delivery/Date | Sex | Weight | Length | Type of Delivery | Hospital | Complications |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Are you allergic to anything: _____Yes _____No

If yes, please list what you are allergic to and your reaction to it.

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |
| | |

Do you have a personal history of any of the following diseases/conditions?
If yes, please list the date of the diagnosis next to the condition.

_____ Abnormal Pap
_____ Alcohol/Drug Abuse
_____ Anemia
_____ Anxiety/Depression
_____ Asthma/Lung Disease
_____ Bladder/Kidney Infections
_____ Blood Clot/Stroke
_____ Breast Problems
_____ Cancer
_____ Crohn's/UC/IBS
_____ Diabetes
_____ Gall Bladder Problems
_____ GERD
_____ Heart Disease/Murmur/Arrhythmia
_____ High Blood Pressure
_____ High Cholesterol
_____ Kidney Disease
_____ Liver Disease
_____ Migraine Headaches
_____ Multiple Sclerosis
_____ Seizure Disorder
_____ Thyroid Problems
_____ Other _____

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Are you currently taking any medications? _____Yes _____No
If yes, please list the medication, dosage, and how long you have been taking the medication.

What pharmacy do you use? _____

| Medication | Dosage | How long have you taken it? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Please list all surgeries you have had.

| Surgery | Date | Hospital | Doctor | Complications |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Do any of the following diseases run in your family? (1st or 2nd degree relatives only)
If yes, please list the relative affected by the disease next to the condition.

_____ Breast Cancer
_____ Ovarian Cancer
_____ Endometrial Cancer
_____ Colon Cancer
_____ Other _____
_____ Blood Clot/Stroke
_____ Hypertension
_____ Diabetes
_____ Heart Disease

Do you smoke cigarettes? _____Yes _____No If so, how many packs per day? _____
How long have you smoked? _____
Do you drink alcohol? _____Yes _____No If yes, do you drink beer, wine, or mixed drinks? (circle all that apply)
How many drinks do you have per week or day? _____
Do you use any other drugs? _____Yes _____No
Are you sexually active? _____Yes _____No What is your sexual preference? _____male _____female _____both
How long have you been with your current partner? _____

Who is your primary care physician? _____
When and where was you last annual done? _____

_____ _____
Patient or Legal Guardian Signature Date