VERIFIED:__________ DATE:__________

**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

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

**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

**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: ______________________

**PATIENT CONSENT FOR OB ULTRASOUND**

*Please read carefully*

______________________________________________________________________
Patient Name

I agree to let my Doctor and Ultrasound Technician perform an ultrasound on me. I understand that the ultrasound is not 100% accurate in determining malformations, gender and congenital defects. I understand that I will be responsible for any charges that are not covered by Medicaid if I have met my limit of ultrasounds.

| ________________________________________ | ____________________________________ |
|---|---|
| Patient Signature | Date and Time |
| ________________________________________ | ____________________________________ |
| Witness Signature | Date and Time |

# OB SCREENING TEST

NAME: _________________________________ SOCIAL SECURITY # __________________________

## CONSENT FOR SCREENING TESTS

I have been informed that as a part of my prenatal care, Lane OB/GYN will perform various screening tests and exams as follows:

- You will have a full physical exam on your first visit. After this you will be examined as needed.
- Routine labs will be performed as needed to include but not limited to:
  - Blood Count
  - Blood Typing
  - Screening for immunity to Rubella (German measles)
  - Screening for immunity to Chicken Pox (not needed if history of chicken pox is documented)
  - Screening for sexually transmitted diseases (gonorrhea, chlamydia, HIV, hepatitis, and syphilis)
  - Screening for birth defects
  - Screening for gestational diabetes
  - Screening for illicit drugs

I have read and agree to have the above mentioned tests performed, as well as any other tests my physician deems medically necessary.

_______________________________________________________ ________________________________

Patient Signature Date

# HIV CONSENT FORM

NAME: ___________________________________ SOCIAL SECURITY #: _________________________

**CONSENT FOR SEROLOGICAL TESTING FOR HIV ANTIBODIES**

I have been informed that a sample of my blood will be drawn and tested to detect HIV antibodies. I have been informed of the purpose and potential uses of the test. By my signature below, I hereby acknowledge that I have read, or have had read to me, this information regarding HIV antibody testing. I have been given the opportunity to ask questions and any questions have been answered to my satisfaction. I acknowledge that I have given consent for performance of this blood test to detect HIV antibodies. I hereby release Lane OB/GYN from any liability or claims arising from the reporting of the results of my test to authorized persons.

_____________________________________________ Patient/Responsible Party Signature

_____________________________________________ Relationship

_____________________________________________ Witness Signature

_____________________________________________ Second Witness (if telephone consent)

_____________________________________________ Date

_____________________________________________ Time

**REFUSAL OF SEROLOGICAL TESTING FOR HIV ANTIBODIES**

I have read the previous consent and have been adequately informed regarding HIV antibody testing. I have decided not to consent to testing. I hereby release Lane OB/GYN from any liability or claims that I may have resulting from my refusal to HIV antibody testing. If a healthcare provider has a significant exposure to blood or body fluid from me or equipment used on me, and if I or my next-of-kin or legal guardian refuse to consent to HIV antibody testing, and a sample of my blood is available, the sample shall be tested for the presence of infectious diseases.

_____________________________________________ Patient/Responsible Party Signature

_____________________________________________ Relationship

_____________________________________________ Witness Signature

_____________________________________________ Second Witness (if telephone consent)

_____________________________________________ Date

_____________________________________________ Time

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 ______________________________________________________________________________

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
_____ Blood Clot/Stroke
_____ Hypertension
_____ Diabetes
_____ Heart Disease
_____ Other ___________________________________________________________________________

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

**Referral Request**

Date: ______________________________

_____Routine _____Urgent

Referring Provider Information:

Referred by: ____________________________ Medical Group: ____________________________

Phone: __________________ Fax: __________________ Completed by: ____________________

Patient Information (Please provide a copy of patient demographics/face sheet):

Patient Name: ______________________________________________ Date of Birth: ____________

Insurance: _______________________________________ Policy #: ____________________________

Reason for Referral:

Diagnosis: __________________________________________________ ICD: ___________________

Has patient had a pap smear at your facility in the last 3 years: _____ If no, when: ____________________

Has patient had STD testing done at your facility in the last year: __________

Has patient had any blood work pertinent to this diagnosis: ______________

Has the patient had any imaging pertinent to diagnosis (Ultrasounds, CT scans, etc.):___________________________

Please include copies of most recent pertinent clinic notes, insurance card (front and back), all labs, path reports, and imaging. Failure to include any of the above mentioned medical information will result in delay in appointment scheduling.

Lane OB/GYN
Care You Can Count On

**OVER THE COUNTER MEDICINE LIST FOR PREGNANT PATIENTS**

**Common Cold**
Sudafed
Sudafed PE
DO NOT TAKE SUDAFED IF YOU HAVE GIVE BLOOD PRESSURE
Benedryl
Robitussin
Mucinex
Sinus Rinse (Neil Med)

**Pain or Headache**
Tylenol (Regular or Extra Strength) as directed

**Yeast Infection**
Monistat
Gyne-lotrimin creams

**Allergies/Itching**
Benedryl

**Heartburn**
Tums
Pepcid
Mylanta

**Constipation**
Milk of Magnesia
Colace
Surfak
Metamucil
Fibercon

**Hemorrhoids**
Preparation H
Anusol
Tucks

***NOTE:*** *As with any medication, follow the product label directions. Although very few to no adverse outcomes have been associated with the above medications, there is no medicine that has been proven 100% safe during pregnancy.*
*If you have any questions, contact our office at (225)-658-1303 or the LDRP Unit at Lane Regional Medical Center at (225)658-4159 (after office hours).*