OLGA JOUKOVSKI, M.D., P.A.

PATIENT REGISTRATION PACKET

DATE:

PATIENT INFORMATION		
Last, First, MI:		
Date of Birth: / /		**Male / Female (circle one)**
SSN:		Marital Status: S / M / W / D / SEP
Address:		City/State/Zip:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Employer:		Occupation:
Employer address:		City/State/Zip:
Email Address:		Race: White / Hispanic / Black / Asian
Primary Care Physician:		Ethnicity: Hispanic / Not Hispanic
Pharmacy Name / Number:		Preferred Language:
How were you referred to our office? Yellow pages / Phone Book / Friend / Insurance / Employer / Other		
PRIMARY INSURANCE		
Primary Insurance Company:		Subscriber ID#:
Last, First, MI:		Group#:
Date of Birth: / /		Male / Female (circle one)
SSN:		
Address:		City/State/Zip:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Employer:		Occupation:
Relationship to Patient:		Email Address:
SECONDARY INSURANCE		
Primary Insurance Company:		Subscriber ID#:
Last, First, MI:		Group #:
Date of Birth: / /		Male / Female (circle one)
SSN:		
Address:		City/State/Zip:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Employer:		Occupation:
Relationship to Patient:		Email Address:
EMERGENCY CONTACT PERSON		
Last, First, MI:		Email address:
Address:		City/State/Zip:
Home Phone: ( )	Work Phone: ( )	Cell Phone ( )

Advanced Directive: Yes / No **if yes:** 1. Do not resuscitate.
2. Spouse / child to make decision

Impaired Vision: Yes / No
Hard of Hearing: Yes / No

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **OLGA JOUKOVSKI MD PA** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **OLGA JOUKOVSKI MD PA** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from **OLGA JOUKOVSKI MD PA** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

______________________________ ____________________

Patient/Responsible Party Signature Date

______________________________ ____________________

Witness Date

OLGA JOUKOVSKI, M.D., P.A.

PATIENT REGISTRATION PACKET

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept VISA, MasterCard and Discover.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment, coinsurance and/or deductible amount at the time of service. Based on your contract between you and your insurance company, your insurance company requires us to collect this payment when you arrive for your appointment. In the event you do not pay at the time of service this office has the right to bill a rebilling fee of $25.00 in addition to any amount that you may owe us.

- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.

- In the event that your health plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

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Printed Name of the Patient

____ ____________________

Signature of Patient or Responsible Party if a Minor Date

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS AND ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I, _________________________, hereby authorize **Olga Joukovski, M.D. P.A,** to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, **Olga Joukovski, M.D. P.A,** can refuse to treat me.

I have reviewed this office's Notice of Privacy Practices which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I am entitled to receive a copy of this document.

I understand that I may revoke this consent at any time by notifying **Olga Joukovski, M.D. P.A.** office, in writing, but if I revoke my consent, such revocation will not affect any action that **Olga Joukovski, M.D. P.A,** took before receiving my revocation.

I understand that **Olga Joukovski, M.D. P.A,** has reserved the right to change his privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that **Olga Joukovski, M.D. P.A,** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that **Olga Joukovski, M.D. P. A.** does not have to agree to such restrictions, but that once such restrictions are agreed to, I must adhere to such restrictions.

I allow **Olga Joukovski, M.D. P.A,** to share my individually identifiable health information with the follow person(s):

______________________________________ ___________________________
Please Print Name Relationship

______________________________________ ___________________________
Please Print Name Relationship

______________________________________ ___________________________
Please Print Name Relationship

________________________________ _____________________
Signature of patient or patient's representative Date

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Printed name of patient or patient's representative (Relationship to the patient is applicable)