

**PATIENT REGISTRATION FORM**

**PATIENT INFORMATION:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
Cell Phone #: \_\_\_\_\_ Marital Status: \_\_\_\_\_

**RESPONSIBLE PARTY – ONLY IF NOT PATIENT:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
Cell Phone #: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**EMPLOYMENT INFORMATION:**

Employer: \_\_\_\_\_ Office Phone # \_\_\_\_\_  
Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

**PRIMARY INSURANCE:**

Company: \_\_\_\_\_ Insured Name: \_\_\_\_\_  
Claims Address: \_\_\_\_\_ Insured DOB: \_\_\_\_\_  
Phone #: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

**SECONDARY INSURANCE (IF APPLICABLE)**

Company: \_\_\_\_\_ Insured Name: \_\_\_\_\_  
Claims Address: \_\_\_\_\_ Insured DOB: \_\_\_\_\_  
Phone #: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

**EMERGENCY NOTIFICATION / NEXT OF KIN – SOMEONE NOT IN HOUSEHOLD**

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF PERSONAL MEDICAL INFORMATION:**

I understand, as outlined in the HIPAA Notice of Patient Privacy Practices, my personal medical information will only be released as it pertains to my medical treatment, payment of charges, or operation of the practice and/or hospital. The practice is also authorized to release my personal medical information to the following individual (s):

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS:**

I authorize the release of any medical information necessary to process my insurance claim. I authorize and request payment of medical benefits directly to my physician. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I understand and agree that, regardless of my insurance status, I am responsible for any balance of my account.

\_\_\_\_\_  
Patient Signature or Responsible Party Signature

\_\_\_\_\_  
Date

PATIENT: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

**PATIENT CONSENT AND AUTHORIZATIONS**

**CONSENT FOR TREATMENT:** I, the undersigned patient, parent or legal guardian, do hereby present myself (or the patient) for care or treatment at the office of Sergey Turchin, M.D., and voluntarily consent to the rendering of such care or treatment, including performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of my physician and it is the responsibility of the practice and its staff to carry out the instructions of such physician. I understand that the physician furnishing services to me is an employee of the hospital, however, other services such as radiology, laboratory, and pathology may be provided by independent practitioners. All physicians expect payment in full upon receipt of a bill and I will assist in billing appropriate insurance companies if insurance or other benefits are involved. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examination in the office. I understand that I am responsible for the outcomes of care or treatment if I do not follow the care, service or treatment plan.

**ASSIGNMENT OF BENEFITS:** I hereby assign payment directly to Sergey Turchin, M.D., the physician accepting this assignment, of all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to Sergey Turchin, M.D. for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay.

**RELEASE OF MEDICAL INFORMATION:** I, the undersigned patient, parent, or legal guardian, do hereby authorize Sergey Turchin, M.D. , the practice's officers and his employees, to release to any third party payor (such as an insurance company or government agency; Example: Blue Cross/Blue Shield of Florida or Medicare) any medical, psychiatric, alcohol, drug abuse, and/or HIV (AIDS or AIDS related complex) treatment information and records, in accordance with the policy of Lawrence Burns, M.D. and any applicable State or Federal Statutes, concerning diagnosis and treatment for the above admission when requested by such third party payor for its use in connection with determining a claim for payment for such care, treatment and/or diagnosis. I authorize the release of any and all medical information to all physicians involved in my care and treatment. I do hereby release Sergey Turchin, M.D. , from all liability that may arise from the release of the information requested.

**FLORIDA LAW:** Section 817.234 Florida Statutes, stipulates that any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**FOR MEDICARE AND MEDICAID PATIENTS ONLY – CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or /or Title XIX 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-carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to Sergey Turchin, M.D. I understand that I am responsible for any health insurance deductibles and coinsurance.

**MEDICARE BENEFICIARY NOTICE OF NON-COVERED SERVICES:** Medicare does not (initials) cover some inpatient, outpatient, and emergency services. Items not covered include, but are not limited to, medications typically self-administered, annual testing and physicals.

**ACKNOWLEDGEMENT OF RECEIPT OF AN IMPORTANT MESSAGE FROM MEDICARE (FOR MEDICARE PATIENTS ONLY):** My signature only acknowledges my receipt of this message from Sergey Turchin, M.D. as dated below and does not waive any of my right to request a review or make me liable for any payment.

**I PERMIT A COPY OF OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH MAY BE ON FILE AT THE OFFICE OF SERGEY TURCHIN, M.D..**

**FINANCIAL AGREEMENT:** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she individually hereby obligates himself/herself to pay the account of Sergey Turchin, M.D. in accordance with the regular rates and terms of the physicians. The undersigned will pay all costs and expenses including reasonable collection fees (which may include agency, attorney, interest or court fees) incurred or paid by the hospital or Sergey Turchin, M.D. in the collection of this obligation by suit or otherwise. Furthermore, I hereby authorize and appoint the administrator of Memorial Health Systems and/or Sergey Turchin, M.D. and/or her successor/designee as my attorney-in-fact to take measures in my behalf as may be necessary to collect such claims or insurance proceeds and to endorse any checks made payable to me for such claims or insurance proceeds by signing my name as attorney-in-fact for me to any such checks and/or insurance claim forms.

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Patient's representative/policy holder or spouse  
Indicate relationship \_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Patient unable to sign due to: \_\_\_\_\_



**FLORIDA HOSPITAL**  
*Memorial Division*

**Acknowledgment of Receipt**  
**Of HealthCare Partners Notice of Patient Privacy Practices**

By signing this Written Acknowledgment of Receipt of (HealthCare Partners) Notice of Patient Privacy Practices ("Acknowledgment"), I hereby expressly acknowledge my receipt of (HealthCare Partners) Notice of Patient Privacy Practices.

\_\_\_\_\_  
Patient, or Legal Representative, Signature

\_\_\_\_\_  
Printed Patient, or Legal Representative, Name (or label)

\_\_\_\_\_  
Date

Acknowledgment **NOT** obtained because:

\_\_\_ Patient, or legal representative, declined Notice of Patient Privacy Practices;

\_\_\_ Other (briefly describe) \_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Employee Printed Name

\_\_\_\_\_  
Date

# MEDICARE SECONDARY PAYER (MSP) QUESTIONNAIRE

Department: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

## I AM ENTITLED TO MEDICARE PART A BENEFITS.

NO       YES      PROCEED TO SECTION I.

### SECTION I

Select the **ONE** statement that is true for you:

- I am over 65 and married. Proceed to section II.
- I am over 65 and not married (includes widowed). Proceed to section III.
- I am under 65, Disabled and currently employed. Proceed to section IV.
- I am under 65, Disabled and unemployed. Proceed to section IV.

### SECTION II

Select the one statement that is true for you:

- My spouse and I are both fully retired. **GO TO SECTION V.**
- I work full or part-time (my spouse is retired) for a company with:
  - LESS than 20 employees. **GO TO SECTION V.**
  - MORE than 20 employees. **GO TO SECTION IV.**
- My spouse works full or part-time (I am retired) for a company with:
  - LESS than 20 employees. **GO TO SECTION V.**
  - MORE than 20 employees. **GO TO SECTION IV.**

### SECTION III

Select the one statement that is true for you:

- I am fully retired. **GO TO SECTION V.**
- I work full or part-time for a company with:
  - LESS than 20 employees. **GO TO SECTION V.**
  - MORE than 20 employees. **GO TO SECTION IV.**

### SECTION IV

Select the one statement that is true for you: *(This does not apply to supplemental plans or employer plans offered during retirement.)*

- I have health care coverage through my employer.     NO       YES
- I have health care coverage through someone else.     NO       YES

IF YES, list name of guardian and relationship

**PROCEED TO SECTION V**

Patient Name.

Medical Record #:

## SECTION V

Is this visit related to an injury due to a fall?

NO  YES

If yes, did the accident occur in  your home  public location  other

Date of Accident: \_\_\_\_\_ *(Claim must be filed with responsible party.)*

Is this visit related to an illness/injury due to an automobile accident?

NO  YES

If yes: Date of Accident: \_\_\_\_\_

RETURN TO THE FRONT DESK AND PRESENT YOUR AUTOMOBILE INSURANCE CARD.

## SECTION VI

Indicate which statements apply to you.

I am entitled to Worker's Compensation for this service.

I am entitled to Black Lung benefits.

I am entitled to VA benefits.

I am entitled ESRD benefits.

I am entitled to COBRA benefits.

I am entitled to other Federal benefits. (UMWA, Gov't research programs, Hospice) Please explain.



