IDL MEDICAL PA
Dr.Diana Gorokhovsky DO

☐ New Patient Information

☐ Change of Patient Information

Patient Information: (PLEASE PRINT CLEARLY)

Mr.
Ms.
Mrs.
Dr. _____

First Name | Middle Name | Last Name

_____ ___/___/_____ ☐Female or ☐Male

Social Security Number | Date of Birth

_____

Address | City, State | Zip Code

_____ _____ _____

Home Phone Number | Work Phone Number | Cellular Phone Number

☐N/A ☐Part Time ☐Full Time _____

Student Status | School Presently Attending

Patient Demographics: (optional)

_____

Ethnic Origin | Marital Status | Blood Type

_____

Emergency Contact | **Relationship** | **Phone Number**

Guarantor Information: (who will be financially responsible for patient) **Check here if self:** ☐

Mr.
Ms.
Mrs.
Dr. _____

First Name | Middle Name | Last Name

_____ ___/___/_____ ☐Female or ☐Male

Social Security Number | Date of Birth

_____

Address | City, State | Zip Code

_____ _____ _____

Relationship to Patient | Home Phone Number | Cellular Phone Number

_____

Employer | Occupation | Work Phone Number

_____ _____

Driver's License or ID Number | State

Insurance Coverage Information:

_____ _____
Insurance Company Name Policy Number

_____ _____
Group Number Effective Date

_____ _____
Primary Insurance Holder (if other than guarantor) **Relationship to Member**

Type of Policy: ☐HMO ☐POS or PPC ☐PPO ☐Medicare ☐Medicaid
☐Medicare HMO

_____ _____
Secondary Insurance Company Name Policy Number Group Number

I understand that payment for services rendered is ultimately my responsibility.

_____ _____
Signature **Date**

IDL MEDICAL PA

Dr.Diana Gorokhovsky DO

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to:

IDL MEDICAL PA/ DIANA GOROKHOVSKY, D.O.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment**.**

Patient's Signature: _____

Date: _____

IDL MEDICAL PA
Dr.Diana Gorokhovsky DO

10075 Jog Road Suite 101

Boynton Beach, FL 33437

PH (561)734-5484

FX (561) 734-5485

I, (Name of patient) ---------- hereby authorize, Dr. Diana Gorokhovsky , and other center employees, to examine and treat me.

I also authorize such treatment and procedures, as deemed necessary by the physician, including but not limited to, the taking of such x-rays, medications, blood samples, urine samples, and other therapies as deemed necessary.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee or assurance has been made or implified to me as to the results that may be obtained by examination and treatment.

I hereby certify that I understand the above authorization.

Date& Time

Patient signature

Patient or person authorize to consent

Relationship to patient

IDL MEDICAL PA

Dr.Diana Gorokhovsky DO

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have received the attached HIPAA Notice of Privacy Practices.

_____

Signature of patient Or representative | Printed name | Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

_____

AUTHORIZATION FOR RELEASE OF ALL MEDICAL RECORDS

Office use only:

To: ----------

Address ----------

City ----------

State ----------

Zip Code ----------

I hereby request that all of my Medical Records with respect to any illness including mental illness, drug or alcohol abuse and HIV – AIDS testing or treatment be released to:

IDL MEDICAL PA

Dr.Diana Gorokhovsky DO

10075 Jog Road Suite 101

Boynton Beach FL 33437

PH (561)734-5484

FX (561)734-5485

Patient Name: ----------

Social security # ----------

Date of Birth ----------

Signature of patient ----------

Witness ---------- **Date: ----------**

A Photostat copy of this authorization is to be considered as valid as the original.

IDL MEDICAL PA

Dr.Diana Gorokhovsky DO

Financial Policy

Thank you for choosing us as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Please understand that payment for services is part of this relationship. The following information outlines our financial policy.

Payment due at the time of service: Co-payments, deductibles, co-insurance and non-covered services are due at the time of service. Acceptable methods of payment are cash, money order, and check, Visa, MasterCard and American Express.
Any check returned by the bank will incur a S25.00 fee.

Account balance: A statement will be issued for unpaid balance; payment for balance is due within 30 days of statement date.

Account past due: If payment is not received within 60 days account will be consider past due and may be turned over for collection. Patient or Guarantor will be responsible for all costs of collection monies owed, including court costs, collection and attorney fees. I further understand that if I fail to make any of the payments for which I am responsible in a timely manner, I will be charged a 1.5% service charge monthly on the remaining balance.

Insurance Updates: We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.

No-Show Policy: A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. "No-shows" inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". The first time there is a "no-show", there will be no charge to the patient. Any additional "no-show" will result in a fee of $25.00 billed to the patient's account.

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered; I have read and understand all the information in the financial policy.

Patient Name_____ DOB _____

Patient/Parent/Guardian Signature_____

Printed Name: _____ Date: _____

DR. DIANA GOROKHOVSKY PA

FAMILY AND FRIENDS CONTACT FORM

Patient Name:_____ DOB_____

By signing this paper below, I give permission to the person(s) listed in the table below to receive information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information that does not pertain to assisting with my health care and any copies of medical records will require a signed HIPPA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Name of Individual	**Relationship to Patient**	**Patient / Guardian Initials**

What is the best way for us to contact you ?

	Phone Number	**Description (Cell, Home, ETC..)**
Primary		
Secondary		
Tertiary		

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Print Name