GJORGJI TRNOVSKI, MD, P.A.

7301 W. PALMETTO PARK RD, SUITE 201C
BOCA RATON, FL 33433
WWW.DRTRNOVSKI.COM (*ability to make appointments online)*

Phone: 561-955-1899
Fax: 561-612-6556

PATIENT INFORMATION: PLEASE PRINT AND ANSWER ALL QUESTIONS

PATIENT'S NAME_____
(LAST) (FIRST) (MIDDLE)

DATE OF BIRTH_____ SEX_____ MARITAL STATUS_____

EMAIL (for patient fusion portal and appointment reminders):_____

FLORIDA ADDRESS_____ APT #_____

CITY_____ STATE_____ ZIP_____

HOME #_____ CELL #_____ PHARMACY #_____

SEASONAL ADDRESS_____APT#_____

CITY_____ST_____ZIP_____

EMERGENCY CONTACT NAME_____PH#_____

INSURANCE INFORMATION

PRIMARY
NAME OF INSURANCE CO._____

NAME OF INSURED_____ INSURED DOB_____

POLICY#_____ GROUP#_____ MEDICARE#_____

SECONDARY
NAME OF INSURANCE CO._____

NAME OF INSURED_____

POLICY#_____ GROUP#_____

ASSIGNMENT OF BENEFITS

I authorize the release of any payment and medical information necessary to process this claim and related claims. I request payment of benefits to GJORGJI TRNOVSKI, M.D., P.A. who accepts assignment of benefits.

_____DATE_____
(Patient's or Authorized person's Signature)

REFERRING PHYSICIAN INFORMATION

PATIENT'S NAME _____

CONSENT FOR TREATMENT

I voluntarily consent to the rendering of care, including treatment, administration of anesthetics and performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of GJORGJI TRNOVSKI, M.D., P.A. and it is the responsibility of the staff to carry out instructions of such physician.

ASSIGNMENT OF BENEFITS

I hereby assign payment directly to GJORGJI TRNOVSKI, M.D., P.A. accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. **I understand that I am financially responsible for the charges not covered by this assignment or for any and all charges, which the insurance carrier declines to pay.** It is further agreed that any credit balance resulting from payment of insurance or other source may be applied to any other accounts owed to said physician(s) by the insured or his/her family.

BILLING

I will be responsible for any services rendered not covered by an additional party. **I understand that I am financially responsible for the charges not covered by the foregoing assignment or for any and all charges, which the insurance carrier declines to pay.** Payment is due upon receipt. Unpaid balances will accrue interest at 1.5% per month or the highest rate allowable by law. If it is necessary, at the sole discretion of the payee, to refer delinquent accounts to a third party for collections, I may be responsible to pay for additional collection fees, costs, and attorneys' fees. Such attorneys fees are separate and in addition to costs.

RELEASE OF INFORMATION

The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient of physician(s) charges, including but limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient' employer.

MEDICARE AND THE MEDICAID PATIENT IDENTIFICATION-AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me, to be released to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request payment for authorized benefits are made on my behalf. I assign the benefits payable for physician(s) services. **I understand that I am responsible for my health insurance deductibles and co-insurance.**

_____ _____

PRINT PATIENT'S NAME **DATE**

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