PATIENT INFORMATION

Name_____ Preferred name_____
(Last) (First) (Middle)

Gender (_)M (_)F SSN_____ Birth Date_____ *Race Code*_____

Marital Status (_) Married (_) Single (_) Widowed (_) Divorced *Ethnic Group*_____

Address _____ Home Phone_____

City _____State _____ Zip _____ Cell Phone_____

Patient Employer/School _____
Employer/School Address _____
Work Phone Number _____
E-mail Address: _____
SPOUSE'S NAME _____ Cell Phone_____

DOB_____ SNN_____

Emergency Contact's (Other than Spouse) Friend/Relative
Name _____
Phone Number (Home) _____ (Cell) _____

PRIMARY INSURANCE

Insurance Name _____
Insured Name _____ Relation to Patient _____
Policy/ID Number _____ Group Number _____
Copy of Card must be made for address and phone number.

SECONDARY INSURANCE

Insurance Name _____
Insured Name _____ Relation to Patient _____
Policy/ID Number _____ Group Number _____
Copy of Card must be made for address and phone number.

PHARMACY _____

ASSIGNMENT & RELEASE

I certify that I, and/or my Dependent(s) have coverage with _____and assign
(Name of Insurance)
directly to Dr. Ivanka Vassileva all insurance benefits, if any otherwise payable to me for service rendered, **I understand that I am financially responsible for all charges whether or not paid by insurance**. I authorize the use of my signature on all insurance submissions.
The above name physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signature of Patient, Parent, Guardian or Personal Representative Date

PRINT NAME: _____
DATE OF BIRTH_____

IVANKA A. VASSILEVA, M.D.
Certified by American Board of Family Practice
4411 W. Gore Blvd., Suite B-10
Lawton, Oklahoma 73505

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I understand that as a part of my health and medical care, Dr. Ivanka Vassileva Family Practice, originates and maintains medical and health records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the health professionals who contribute to my care
- a source of information for applying my diagnosis and treatment information to my bill
- a means for a third-party payer to verify that services were billed as actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a PATIENT PRIVACY NOTICE that provides a more complete description of information uses and disclosures. I understand that I have the right to review the PATIENT PRIVACY NOTICE prior to signing this consent. I understand that Dr. Vassileva reserves the right to change her notice and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object of the use of my health information for directory purposes. In understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Dr. Vassileva is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law we are required to notify you . . . that the information authorized for release may include records, which may indicate the presence of a communicable, or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human deficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Information may be release to the following organizations for the indicated purposes:

_____ _____
_____ _____

I request the following restrictions to the use and/or disclosure of my health information: _____
_____
_____

X _____ X_____
Signature of Patient or Legal Representative Date Notice Effective

Dr. Ivanka Vassileva ____ accepts _____ denies _____ accepts conditionally