

Finger Lakes Hematology & Oncology

Stephen M. Ignaczak, M.D.
Bruce A. Yirinec, M.D.

6 Ambulance Drive
Clifton Springs, NY 14432
Telephone: 315-462-1472
Fax: 315-462-2639

Patient Registration Form

| | | | | | | |
|---|----------------|------------|----------------------------|---------------------------------------|----------------------|-----------------|
| Social Security Number | | Last Name | | First Name | | Middle Initial |
| | | | | | | |
| Street Address/P.O. Box | | | City | | State | Zip |
| | | | | | | |
| Home Phone | | Cell Phone | Date of Birth | | Alias or Maiden Name | |
| | | | | | | |
| Sex | Marital Status | | County | | Race - Optional | |
| Male | Single | Widowed | | | White | Hispanic |
| Female | Married | Divorced | | | Black | Native American |
| | | | | | Asian | Other |
| Who is your Primary Care Physician? | | | Other doctors that you see | | | |
| | | | | | | |
| Employer | | Address | | City/State/Zip | | |
| | | | | | | |
| Occupation | | Work Phone | | Can we call you at work? | | |
| | | | | Yes No | | |
| Who Referred you to Finger Lakes Hematology & Oncology? | | | | | | |
| | | | | | | |
| Pharmacy Name | | | | Pharmacy Phone | | |
| | | | | | | |
| Pharmacy Address | | | | City/State/Zip | | |
| | | | | | | |
| Pharmacy Insurance or Provide Copy of card | | | | Policy Number or Provide copy of card | | |
| | | | | | | |
| Medical Insurance | | | | | | |
| Primary Insurance | | | | Copy of Card Provided | | |
| | | | | Yes No | | |
| Secondary Insurance | | | | Copy of Card Provided | | |
| | | | | Yes No | | |

As the patient or guarantor, I certify that the information on this form is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills, including co-pays at time of service unless other arrangements are made. I authorize physician and officeto release any information to process insurance claims. I also authorize my insurance claims to be paid directly to the office.

Patient/Guarantor Signature

Date

PRINT NAME

**UNIFORM ASSIGNMENT AND RELEASE OF
INFORMATION STATEMENTS**

I hereby authorize release of information in relation to medical treatment by **Finger Lakes Hematology and Oncology** to the insurance carriers, or others who are financially liable for my medical care all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Date

Signature of Patient or authorized representative

I hereby assign to **Finger Lakes Hematology and Oncology** sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or to others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependents.

Date

Signature of Patient or authorized representative

**ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
PATIENT RIGHTS AND RESPONSIBILITIES**

I hereby acknowledge that I have been provided a copy of, or been offered to the opportunity to receive of the **Finger Lakes Hematology and Oncology** Notice of Privacy Rights and a copy of the Patient Rights and Patient Responsibilities.

Date

Signature of Patient or authorized representative

**FOR PATIENTS ENTITLED TO MEDICARE BENEFITS
LIFETIME AUTHORIZATION**

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this on my behalf to the physicians or organization furnishing the services provided to me. I authorize any holder of medical information about me to release to the MEDICAP insurer any information needed to determine these benefits payable for related services. I request that payment under the medical insurance program be made either to me or to any physician for services provided to me.

Date

Medicare Beneficiary Signature

Name-**PLEASE PRINT**

Patient Name: _____ **DOB:** _____

PLEASE RELEASE MY MEDICAL RECORDS AND ANY PERTINENT
INFORMATION TO:

Finger Lakes Hematology & Oncology, PLLC
Stephen M. Ignaczak, MD
Bruce A. Yirinec, MD
6 Ambulance Drive
Clifton Springs, NY 14432

Signed: _____

Date: _____

WITNESS: _____

Release of PHI To Others Involved in Your Healthcare

As stated in our Notice of Privacy Practices, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We request that you designate the individuals with whom we may discuss your protected health information.

Can FLHO acknowledge that you are a patient here? Yes ___ No ___

I, _____ give **Finger Lakes Hematology & Oncology**
(please print)
 permission to discuss my protected health information with the following persons:

| Name | Relation | Phone Number |
|-------|----------|--------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Emergency Contact: _____ Phone number _____
 Address: _____

I also give permission to **Finger Lakes Hematology & Oncology** personnel to leave messages on voice mail, telephone recorder or with person answering phone. (circle one) **YES** **NO**

Name and address of nearest relative not living at your address:
 Name _____ Address _____
 City _____ State _____ Zip Code _____
 Telephone _____ Relationship _____

| | | | |
|-----------------------|-------|-------------------|------|
| Patient Signature | Date | Witness Signature | Date |
| Patient Date of Birth | _____ | | |

I understand that I may rescind or modify this permission at any time. Such change must be in writing to Finger Lakes Hematology & Oncology.

Finger Lakes Hematology & Oncology
Advance Directive Questionnaire

Patient Name _____ DOB: _____ Date _____

Finger Lakes Hematology would like to encourage all patients to have an Advance Directive on file with our office.

Under the Patient Self-Determination Act of 1990, each individual has the right to determine the course of his/her medical care and treatment. You make these choices now so that when you become unable, your decisions are known. Advance Directives only take effect if, in the future, you lose the capacity to speak for yourself. It has no effect on your current health care as long as you are able to speak for yourself.

Advance Directives for Health Care consist of three parts: Health Care Proxy, Living Will and Other Wishes.

Health Care Proxy : Designates another person to make medically related decisions for you.

Living Will: Designates your future health care treatment choices.

Other Wishes: Designates your wishes regarding Death, Organ Donation and Autopsy.

You may, at any time, complete any section and our office will keep a copy of your wishes on file for you. If you are not ready today please ask at any time for the form. We will review this annually with you.

Do you have a living will? YES NO

Do you have a Health Care Proxy? YES NO

If no, would you like the form to fill out? YES NO

If yes, would you like to have a copy in our chart for you? YES NO

I am not ready to fill out this form. Please ask me about this in the future. _____

I am not ready to fill out this form. Please do not ask me about this again. _____

Patient Signature _____

Date _____

Office use:

Gave patient Advance Directives form _____

Patient completed form and filed in chart _____

Reviewed with Patient _____