Dr. Michael Yerukhim
EAR, NOSE AND THROAT
FACIAL PLASTIC SURGERY

Patient Information

Primary Care Physician: ____

Name: _______ **Date of Birth:**____________
SSN: _______________________________________ **Sex:**__
Address: ________________________________

____
Home Phone: _________________ **Cell Phone:** _________
Work Phone: ___________________ **Language:** ______________________
Marital Status: _____________ **Race:**_____________________
Email Address: _____________________ **Ethnicity:** Hispanic/Latin   Non-Hispanic/Latin   Decline

Insurance Information

Primary Insurance: _______________________
Subscriber Name: ________________________ Date of Birth: _
Subscriber ID: _______________________________

Secondary Insurance: ____________________________
Subscriber Name: _______________________________ Date of Birth: _
Subscriber ID: ___________________________

Pharmacy Information

Pharmacy Name: ____
Phone Number: ____
Address: ____

Rx History Consent: I hereby authorize Michael Yerukhim M.D. to obtain my previous prescription/medication history through external sources. ________ **(initials)**

What is your preferred contact number for appointment reminders and messages?

Preferred Phone#: ___________________________________

On occasion, we may need to call you and leave information regarding results of any treatments or tests that you have had.
May we leave this information on your voicemail? ☐ Yes ☐ No
If yes please circle preferences:

Home Phone or Cell Phone. Type of Message: Brief or Extended

Would you like to be web enabled for our patient portal? ☐ Yes ☐ No

If yes please provide your email address ____

In order for us to service our account or to collect any amounts you may owe, we, as well as any agency contracted by us, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We, as well as any agency contracted by us, may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

All professional services rendered are charged to the patient, necessary forms will be completed to help expedite insurance carrier payments. If you are covered by a plan with a restrictive network, it is your responsibility as the insured/patient to seek professional care with a participating provider within your plan. The patient (or guardian) is responsible for all fees, regardless of insurance coverage

I hereby give the physicians of Michael Yerukhim, MD LLC permission to treat me or my dependent(s), and I authorize Michael Yerukhim MD LLC to furnish any medical information necessary for insurance claim submission and/or payment. I understand that I am responsible for any remaining fees not covered by insurance.

I further understand that some or all of the services rendered may be deemed "non-covered" by my insurance carrier and that I will be billed for such services.

I authorize payment of medical benefits Michael Yerukhim, MD LLC for services described herein. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees and services rendered.

DISCLOSURE OF PERSONAL HEALTH INFORMATION

Michael Yerukhim, MD LLC has implemented an electronic medical record in order to improve the efficiency in our offices and provide the highest quality healthcare services to our patients.

Michael Yerukhim, MD adheres to the standards as defined for privacy of individually identifiable health information; which is commonly referred to as the privacy rule. The Privacy Rule standards address the use and disclosure of individuals' health information better known as PHI (Protected Health Information). Also, Michael Yerukhim, MD follows the regulations associated with the Health Insurance Portability and Accountability Act (HIPAA); a notice of our privacy practices is available to you upon request.

We need to obtain your permission to release or share your protected health information. Please complete this form in order for Michael Yerukhim, MD LLC to release your medical records.

Personal Health Information Release / Emergency Contacts:

Name: ______________________________

Relationship: ______________________________

Home Phone #: ______________________________

Cell Phone #: ______________________________

Is this person able to receive your Personal Health Information? Yes No

Name: ______________________________

Relationship: ______________________________

Home Phone #: ______________________________

Cell Phone #: ______________________________

Is this person able to receive your Personal Health Information? Yes No

I, ______________________, do hereby acknowledge notification of the Notice of Privacy Practices, Policies, and Procedures.

Patient Signature: ______________________________ **Date:** ______________

Parent/Guardian Signature: ______________________________ Date: ______________

STANDARD AUTHORIZATION FORM

Fields marked with an asterisk (*) are required to be completed. Failure to provide additional identifying information in Section I may result in the inability to respond to this request. This form is not a patient access request under 45 CFR 164.524. *Records released pursuant to this authorization may include information concerning testing, diagnosis or treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual assault.*

FORM A- AUTHORIZATION FOR RELEASE OF INFORMATION FROM COVERED ENTITIES (OTHER THAN PART 2 PROGRAMS)

Section I				
First Name*	M.I.	**Last Name***	**Date of Birth***	Social Security Number
Address			City, State, Zip	
I hereby authorize the disclosure of health information about the above individual as follow.				

Section II		
Disclosing Entity* Carequality/CommonWell/University Hospitals of Cleveland (&affiliates)/Cleveland Clinic Hospital (&affiliates)/Premier Physicians/NOMS/ Other: ____________________		
Address:	Telephone Number:	
City:	State:	Zip:
Recipient: (Person or Entity): **Michael Yerukhim, MD**		
Contact Information (e.g. telephone number, email address, fax number, street address, etc.) **7215 Old Oak Blvd. Ste A414 Middleburg Heights, Ohio 44130-3377 Phone: 440-816-2776 Fax: 440-816-2709** **Email: DrYerukhim@MYEntPlastics.com**		

Section III

Reason for Disclosure*

For medical treatment or consultation, billing or claims payment, or other purposes as the patient may direct.

Health information to be disclosed*
Release of complete health record. I am aware that there may be information in my medical record that relates to substance abuse, mental illness or HIV/AIDS that is of a highly confidential level.

Specify time period if desired:

Release only information from the period __________________(mm/dd/yyyy) to _______________(mm/dd/yyyy)

Section IV

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date of event is specified below, this authorization will expire in one year.

Expiration Date or Event ______________________________________(mm/dd/yyyy)

- I understand that I may not be denied treatment payment, and enrollment in the health plan, or eligibility for benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law.
- I understand that information disclosed by this authorization, except as prohibited by 42CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45CRF Part164]

Signature of Individual*	**Date* (mm/dd/yyyy)**
Signature of Personal Representative (if applicable)* (identify relationship to the individual below)	**Date* (mm/dd/yyyy)**

Relationship of Personal Representative to Individual (Personal representative shall submit proof of authority to the disclosing entity)

☐ Parent ☐ Legal Guardian ☐Healthcare Power of Attorney ☐ Executor/Administrator ☐ Other ☐N/A