DR. DAVID TURBAY

REGISTRATION FORM

(Please Print)

Today's date:	PCP/Referring MD:

PATIENT INFORMATION

Patient's Last name: First:	Date of Birth:	Sex: ☐ M ☐ F	Marital status (circle one) Single / Mar / Div Sep / Wid
Street address:			Social Security Number:
Email address: *(For enrollment in online health portal)*	Home phone no.: ( )		Alternate phone no.: ( )
Occupation:	Employer:		Employer phone no.: ( )
Pharmacy (Name, Address, Phone Number)			

IN CASE OF EMERGENCY / RELEASE OF INFORMATION

Name of local friend or relative:	Relationship to patient:	Date of Birth:	Phone no.: ( )

CONSENT / AUTHORIZATION

_____*(Initials)* **Consent to Treat**: I hereby consent for Dr. David Turbay to render medical services and counsel to me. I authorize the release of any medical information necessary for my medical treatment.

_____*(Initials)* **Notice of Privacy Practices**: I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

_____*(Initials)* **Release of Information**: I authorize the release of information to my primary and/or my referring provider for informational purposes and to be taken into consideration in the coordination of my care. I further authorize David Turbay, MD and his staff to release specified medical information regarding my condition and treatment to the individual specified above on my behalf. (This authorization is NOT a substitution for a medical power or attorney.)

_____*(Initials)* **Responsibility for Payment**: I authorize the release of any medical information necessary to process my insurance claims. I authorize payment to be made directly to Dr. Turbay for services described on any claim forms filed on my behalf. ***I understand that I am financially responsible for all charges not paid by my insurance company.***

_____*(Initials)* **No Show/Cancellation Fee**: There will be a $25.00 fee for appointments not cancelled within one (1) working day in advance of your scheduled appointment.

_____*(Initials)* **Follow My Health Portal**: I certify that I (*or my representative*) am the owner of the email address provided. I.authorize Dr. David Turbay and designated staff to enroll the email provided in the FMH portal which will provide me access to my medical record.

The above information is true to the best of my knowledge.

_____ _____

Patient/Guardian signature *Date*

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