

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES					
PATIENT NAME (FIRST – MIDDLE INITIAL -- LAST)			ADDRESS (STREET - APT # (if necessary) - ZIP)		
CITY, STATE		EMAIL		HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____	
ETHNICITY <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined to answer			LANGUAGES <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> Portuguese <input type="checkbox"/> French <input type="checkbox"/> Italian <input type="checkbox"/> Other _____		
RACE <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Declined to answer <input type="checkbox"/> Other _____					
PATIENT EMPLOYER NAME		EMPLOYER ADDRESS (CITY – STATE)		EMPLOYER PHONE	
INSURED/RESPONSIBLE PARTY INFORMATION			HOW MAY WE CONTACT YOU:		
INSURANCE: <input type="checkbox"/> SELF PAY: <input type="checkbox"/>			Please select all that apply		
INSURANCE PROVIDER: _____			<input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Okay to leave voicemail		
SUBSCRIBER: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> parent					
IN CASE OF EMERGENCY CONTACT			RELATIONSHIP	PHONE NUMBER	
REFERRED BY: <input type="checkbox"/> Internet (Which Website?) _____ <input type="checkbox"/> Insurance Company <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Newspaper/Magazine (Which one?) _____ <input type="checkbox"/> Friend/Family Member (Who?) _____ <input type="checkbox"/> Doctor _____ <input type="checkbox"/> Other _____					
PREFERRED PHARMACY (please include as much information as you can)					
PHARMACY NAME			ADDRESS		
CITY & ZIP		PHONE		CROSS STREETS	
ARE YOU INTERESTED IN ANY OF THE FOLLOWING?					
<input type="checkbox"/> Anti-aging	<input type="checkbox"/> Latisse for eyelashes	<input type="checkbox"/> Micro-needling/PRP	<input type="checkbox"/> Acne/Acne Scars/Rosacea		
<input type="checkbox"/> Fillers	<input type="checkbox"/> Hair Loss/Thinning	<input type="checkbox"/> Peels/Facials	<input type="checkbox"/> Vitamins		
<input type="checkbox"/> Botox	<input type="checkbox"/> Scar Revision	<input type="checkbox"/> Skincare Products	<input type="checkbox"/> Other: _____		

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.	
SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

PATIENT MEDICAL HISTORY

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FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

Please circle:	MOTHER (living or deceased)	FATHER (living or deceased)	SIBLING (Brother/Sister) (living or deceased)
Anesthesia Problems			
Arthritis			
Cancer (indicate type)			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			
Other			

SOCIAL HISTORY

Children: Yes No If Yes, How Many? _____
 Yes No - Do you drink alcohol? Daily Weekly Socially Recovering Alcoholic
 Yes No - Do you use tobacco? Smoke (___ packs per day) Chew Former Tobacco User
 Yes No - Do you use illicit drugs? If so, which ones/how often? _____
 Yes No - Do you consume caffeine? If so, what type/how often? _____

FEMALES ONLY

First Day of Last Menstrual Period _____ Menopause _____ (indicate date or age)
 Have you been pregnant before? Yes No If yes, how many times? _____
 Are you pregnant now? Yes No

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had, including dental surgery.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Allergies NONE/No Known

- | | | | |
|---|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Wheat | <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dairy Products | <input type="checkbox"/> Latex | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Morphine | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Iodine/Contrast Dye | <input type="checkbox"/> Shellfish | |

PLEASE INDICATE REACTION:

Medical History: Have you ever had any of the following? (please check all that apply)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> NONE of the problems listed | | | |
| <input type="checkbox"/> allergies, seasonal | <input type="checkbox"/> chronic fatigue syndrome | <input type="checkbox"/> recent infection _____ | <input type="checkbox"/> onychomycosis (fungus) |
| <input type="checkbox"/> anemia | <input type="checkbox"/> depression | <input type="checkbox"/> irritable bowel syndrome (IBS) | <input type="checkbox"/> melanoma |
| <input type="checkbox"/> arthritis conditions | <input type="checkbox"/> anxiety | <input type="checkbox"/> kidney problems | <input type="checkbox"/> eczema |
| <input type="checkbox"/> asthma | <input type="checkbox"/> insomnia | <input type="checkbox"/> kidney stones | <input type="checkbox"/> psoriasis |
| <input type="checkbox"/> atrial fibrillation | <input type="checkbox"/> diabetes, type I | <input type="checkbox"/> menopause | <input type="checkbox"/> sunburn with blisters |
| <input type="checkbox"/> bleeding problems | <input type="checkbox"/> diabetes, type II | <input type="checkbox"/> organ injury | <input type="checkbox"/> skin cancer _____ |
| <input type="checkbox"/> CAD, coronary artery disease | <input type="checkbox"/> drug/alcohol abuse | <input type="checkbox"/> osteoporosis | |
| <input type="checkbox"/> cardiac arrest | <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> pulmonary embolism | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> pacemaker | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> blood clot in legs | |
| <input type="checkbox"/> defibrillator | <input type="checkbox"/> GERD, reflux disease | <input type="checkbox"/> seizure disorders | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> heart disease | <input type="checkbox"/> shortness of breath | |
| <input type="checkbox"/> CHF congestive heart failure | <input type="checkbox"/> high cholesterol | <input type="checkbox"/> sinus conditions | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> migraines | <input type="checkbox"/> hypertension/high blood pressure | <input type="checkbox"/> sinusitis | |
| <input type="checkbox"/> headaches | <input type="checkbox"/> hypothyroidism | <input type="checkbox"/> stroke | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> BPH | <input type="checkbox"/> infertility (female) | <input type="checkbox"/> syndrome X | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> gestational diabetes | <input type="checkbox"/> infertility (male) | <input type="checkbox"/> tremors | |
| <input type="checkbox"/> urinary tract infection (UTI) | <input type="checkbox"/> hypogonadism male | <input type="checkbox"/> celiac disease | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> cancer _____ | <input type="checkbox"/> inflammatory bowel syndrome
(Crohn's disease or Ulcerative colitis) | <input type="checkbox"/> Parkinson's Disease | |
| | | <input type="checkbox"/> neuropathy | |

Elite Medicine and Aesthetic Institute
Fawn Winkelman, D.O.
1905 Clint Moore Road, Suite 203, Boca Raton, FL 33496
Telephone (561) 826-6650 Fax (561) 826-6649

Acknowledgement of Receipt of Privacy Notice

I hereby acknowledge that I have received a copy of Elite Medicine and Aesthetic Institute's Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

___ Guardian or conservator of an incompetent patient

___ Guardian or parent of child (minor)

Name of Patient (Please Print): _____

Patient Contact

All calls regarding your care, test results, and appointments will be made to your preferred phone number. If you would like us to contact you at an alternate phone number, please indicate that number here:

(_____) _____

___ I hereby authorize this office to contact me by telephone and if I am not present, they may leave a message on my answering machine.

___ If you prefer that we do **NOT** leave messages on your answering machine.

Other Contact Information

If you would like us to speak to people other than a duly designated guardian or conservator about your medical condition or billing information, please ask a staff member to give you a copy of our Permission to Release Information form. You will need to complete one of these forms for each person you would like us to speak to.

For office use only:

Signed form received by: _____ Initials: _____

Acknowledgement Refused: ___ Efforts to Obtain: _____

Reason: _____

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Practice Guidelines

Please Initial next to EACH line acknowledging your agreement to and acceptance of the following additional terms of this Agreement.

_____ **Insurance:** Elite Medicine and Aesthetic Institute will contact your insurance company in order to obtain benefits. In the event that the benefits information given to Elite Medicine and Aesthetic Institute is different than what your insurance company actually pays, you will be responsible for the additional fees required by your insurance company.

_____ **Prescriptions:** To allow us to serve all our patients efficiently, Elite Medicine and Aesthetic Institute expects you to be responsible to make sure you have enough medication to last you to the next visit. If you run out of a prescribed medication or forgot to ask for a refill, an office visit will be required. If this is not possible, the doctor may authorize a refill on your prescription for a one time courtesy, but a **\$15.00** fee may be charged on your next visit until you can make an appointment to be seen. If you cancel or do not show up for your appointment, Elite Medicine and Aesthetic Institute reserves the right to collect the \$15.00 prescription fee.

_____ **Labs and Diagnostic Tests:** There is a **\$15.00** charge for the convenience of collecting your specimens in the office (blood draw). You may request at any time to go to the lab (Quest or LabCorp) for your blood work. Most insurances cover outside lab collection at no additional charge. All labs and diagnostic tests require a follow up visit with the provider to go over the results and insure continuity of care. No results will be given over the telephone unless directed by the physician on the day your test is ordered. It is your responsibility to make a follow up appointment to review the results with your physician.

_____ **Emergencies:** Elite Medicine and Aesthetic Institute will make every effort to receive your calls and respond promptly in an emergency. If you do not receive an immediate response you should call 911 for paramedic intervention, or seek the nearest emergency room.

_____ **Appointments:** Elite Medicine and Aesthetic Institute will be respectful of your time and we ask you would be respectful of ours. Appointments can be scheduled online for your convenience. Please arrive 20 minutes prior to your appointment to register. Cancellations must be made with a minimum of **24-hour** notice (or Friday before a Monday appointment time) as a courtesy to other patients seeking services. A fee of **\$50.00** will be charged for non-cancelled or missed appointments. A pattern of non-cancelled/missed appointments may result in discharge from the practice. Minors must be accompanied by a parent or guardian to be seen unless special arrangements have been made with the office.

_____ **Forms Fees:** Elite Medicine and Aesthetic Institute charges for additional paperwork outside of the completion of the medical record. The following fees apply and are subject to change without notice to forms including but not limited to: FMLA, immigration, disability, driver's license, disabled and school physical forms. The fee to fill out forms is **\$35.00**. Additional fees may apply at the discretion of the practice and upon notification to you.

_____ **Medical Records:** The medical chart is the property of the practice. However, copies of your pertinent medical information are available upon request. The practice charges a fee for a copy of the records of \$1.00 per page up to \$25.00, then 0.25 cents per page after the first 25 pages.

_____ **Insurance copayments, deductibles and coinsurance:** Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. All copayments, deductibles, coinsurance, or non-covered services are to be paid at the time of your visit.

_____ **Accident & Worker's Compensation:** Elite Medicine and Aesthetic Institute does not treat accident or worker's compensation patients at this time.

_____ **Statement Policy:** Elite Medicine and Aesthetic Institute sends patient statements each month. Payments are due upon receipt of the statement. If we participate with your insurance company, the sending of a statement may be delayed until your insurance responds to the claim for services. These delays can take months. A delay does not alter our policy of patient financial responsibility, and you will be liable for all service fees. A late fee may be charged for balances that are more than 30 days old.

_____ **Collection and Bank fees:** Accounts more than 90 days old are subject to transfer to an outside collection agency. These agencies charge fees. You will be liable for all such collection expenses, legal fees, and court costs. In addition, banks charge for checks that do not clear or cannot be cashed and you will be held accountable for all such fees with a minimum charge of **\$35.00**.

_____ **Patient Discharge:** The practice reserves the right to release a patient for any reason. This may occur for failure to meet your obligations under this document or failure to comply with the treatment plan(s) as outlined by your practitioner.

Name _____ Signature _____

Responsible Party _____ Relationship _____ Date _____

**Elite Medicine and Aesthetic Institute
Fawn Winkelman, D.O.**

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

Patient Name _____ Date _____

Check here if patient is a minor or unable to provide consent

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals as I have designated below. I understand that the information may also be used in advertising. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive.

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand. **PLEASE CHECK ONE OF THE FOLLOWING BELOW**

I **CONSENT** for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications as well as advertising and social media accounts. Including but not limited to Facebook, Twitter, Instagram, and LinkedIn. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.

Signature _____ Witness _____

I agree for use of my image for my **medical records ONLY**:

Signature _____ Witness _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name of Patient _____ Date of Birth _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

INFORMATION TO BE RELEASED OR ACCESSED:

- | | |
|---|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> X-Ray Reports/Images |
| <input type="checkbox"/> Lab/Path Reports | <input type="checkbox"/> Entire Medical Record |

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number _____

Address (Street, City, State and ZIP)

FROM:

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number _____

Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire one year from the date of my signature, unless I revoke the authorization prior to that time.

Name _____ Signature _____

Responsible Party _____ Relationship _____ Date _____

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Fawn Winkelman D.O.

Advance Beneficiary Notice (ABN) for LABS and PROCEDURES

Patient Name: _____ DOB: _____

We expect that your insurance company will not pay for the item(s) or service(s) that are described below. Your Insurance Company does not pay for all of your healthcare costs. Your Insurance Company only pays for covered items and services when your insurance company's rules are met. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it.

There may be a good reason your doctor recommended it. Right now, in your case, your Insurance Company probably will not pay for:

Item or Service: LABS, EKG, EAR LAVAGE, SKIN BIOPSY, ETC.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you do not understand why your Insurance Company may not pay.
- Ask us how much these items or services will cost you (*Estimated Cost:* \$)

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE.

Option 1: Yes, I want to receive these items or services.

I understand that my Insurance Company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company. I understand that you may bill me for items or services and that I may have to pay the bill while my Insurance Company is making its decision. If my insurance company does pay, you will refund me any payments I made to you that are due to me. If my Insurance Company denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my Insurance Company's decision.

Option 2: No, I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance company and that I will not be able to appeal your opinion that my insurance company will not pay.

PATIENT SIGNATURE

DATE