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

Date: _____

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (FIRST – MIDDLE INITIAL -- LAST)	ADDRESS (STREET - APT # if necessary)		
CITY, STATE, ZIP	EMAIL	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Other_____

ETHNICITY ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined to answer

LANGUAGES ❑ English ❑ Spanish ❑ Creole ❑ Portuguese ❑ French ❑ Italian ❑ Other_____

RACE ❑ White ❑ Black/African American ❑ Asian ❑ American Indian/Alaska Native ❑ Native Hawaiian/Pacific Islander ❑ Declined to answer ❑ Other _____

PATIENT EMPLOYER NAME	EMPLOYER ADDRESS (CITY – STATE)	EMPLOYER PHONE

INSURED/RESPONSIBLE PARTY INFORMATION

INSURANCE: ❑ **SELF PAY:** ❑

INSURANCE PROVIDER: _____

SUBSCRIBER: ❑ self ❑ spouse ❑ parent

HOW MAY WE CONTACT YOU:

Please select all that apply

❑ Email ❑Phone ❑Mail ❑ Okay to leave voicemail

IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

REFERRED BY:

❑ Internet (Which Website?) _____ ❑ Insurance Company ❑ Current Patient _____

❑ Newspaper/Magazine (Which one?) _____ ❑ Friend/Family Member _____

❑ Doctor _____ ❑ 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?

❑ Anti-aging	❑ Latisse for eyelashes	❑ Micro-needling/PRP	❑ Acne/Acne Scars/Rosacea
❑ Fillers	❑ Hair Loss/Thinning	❑ Peels/Facials	❑ Vitamins
❑ Botox	❑ Scar Revision	❑ Skincare Products	❑ Other: _____
		❑ Non-Surgical Fat Loss	

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

PLEASE PRINT AND COMPLETE ALL ENTRIES

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

❑ Wheat ❑ Adhesive Tape ❑ Penicillin ❑ Other _____

❑ Dairy Products ❑ Latex ❑ Aspirin ❑ Other _____

❑ Codeine ❑ Morphine ❑ Sulfa Drugs ❑ Other _____

❑ Anesthesia ❑ Iodine/Contrast Dye ❑ Shellfish

PLEASE INDICATE REACTION:

_____

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

❑ NONE of the problems listed

❑ allergies, seasonal
❑ anemia
❑ arthritis conditions
❑ asthma
❑ atrial fibrillation
❑ bleeding problems
❑ CAD, coronary artery disease
❑ cardiac arrest
❑ pacemaker
❑ defibrillator
❑ chest pain
❑ CHF congestive heart failure
❑ migraines
❑ headaches
❑ BPH
❑ gestational diabetes
❑ urinary tract infection (UTI)
❑ cancer _____

❑ chronic fatigue syndrome
❑ depression
❑ anxiety
❑ insomnia
❑ diabetes, type I
❑ diabetes, type II
❑ drug/alcohol abuse
❑ erectile dysfunction
❑ fibromyalgia
❑ GERD, reflux disease
❑ heart disease
❑ high cholesterol
❑ hypertension/high blood pressure
❑ hypothyroidism
❑ infertility (female)
❑ infertility (male)
❑ hypogonadism male
❑ inflammatory bowel syndrome (Crohn's disease or Ulcerative colitis)

❑ recent infection _____
❑ irritable bowel syndrome (IBS)
❑ kidney problems
❑ kidney stones
❑ menopause
❑ organ injury
❑ osteoporosis
❑ pulmonary embolism
❑ blood clot in legs
❑ seizure disorders
❑ shortness of breath
❑ sinus conditions
❑ sinusitis
❑ stroke
❑ syndrome X
❑ tremors
❑ celiac disease
❑ Parkinson's Disease
❑ neuropathy

❑ onychomycosis (fungus)
❑ melanoma
❑ eczema
❑ psoriasis
❑ sunburn with blisters
❑ skin cancer _____

❑ other _____

❑ other _____

❑ other _____

❑ other _____

❑ other _____

Medications: List any medications you are currently taking (please include over the counter medications, vitamins, herbs, or supplements):
PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATIONS/VITAMINS	DOSAGE	PRESCRIBING DOCTOR

PREVENTATIVE CARE

CANCER SCREENING	DATE LAST PERFORMED
Mammogram or Breast Ultrasound	
Pap Smear	
Colonoscopy or Cologuard	
Chest X-Ray	
PSA Level in Blood or Exam (Prostate)	

IMMUNIZATIONS/VACCINATIONS	DATE LAST PERFORMED
Influenza/Flu	
TdaP (Tetanus Diptheria Pertussis)	
Pneumonia	
Meningitis	
Shingles	
Hepatitis B	

PREVENTATIVE SCREENING	DATE LAST PERFORMED
Annual Wellness Visit with Blood Panel	
Annual EKG, if necessary	
STD Check / HIV Check	
Annual Dental Exam	
Annual Eye Exam	
Annual Derm or Skin Cancer Exam	
Hepatitis B Check	
Diabetes Check	
Foot Exam	
Osteoporosis Screening	
Abdominal Aortic Aneurysm Screening	

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 (i.e., 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. 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, immunization, biometric or wellness forms, and school or sports 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.

Print Name _____ Signature _____

Responsible Party _____ Relationship_____ Date _____

Elite Medicine and Aesthetic Institute
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Phone: 561-826-6650
Fax: 561-826-6649

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:

- ☐ History & Physical
- ☐ Operative Reports
- ☐ Lab/Path Reports
- ☐ Consultation Reports
- ☐ X-Ray Reports/Images
- ☐ 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.

Print Name _____ Signature _____

Responsible Party _____ Relationship_____ Date _____

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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_____

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

Signature_____

Fawn Winkelman, DO
Elite Medicine & Aesthetic Institute

Office Financial Policy

Patient Name (print):_____

To the patient: We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

Medicare Patients:

We are a Medicare participating provider and we will bill Medicare carriers. You will be responsible at the time of service for the payment of:

- The annual deductible(s)
- Co-payments
- Charges for non-covered or cosmetic services*

*You will be asked to sign an Advanced Notice of Liability Form in the event that a service is provided which we know is not covered by Medicare.

Non-Medicare/Commercial Plans or Uninsured (Cash) Patients:

If we participate or are contracted with a commercial insurance plan under which you are covered, we will bill the carrier for all charges and services rendered. We will bill both your primary and secondary insurance plans. You will be responsible at the time of service for payment of:

- The annual deductible(s)
- Co-payments
- Charges for non-covered or cosmetic services*

In the event that you, as the patient, or we as the provider are not aware of a charge that is not covered by your plan, you will be billed for the balance after we obtain a denial from your insurance carrier.

Laboratory Services:

In the event that you, as the patient, agree to have laboratory services rendered, you will be responsible for payment of charges that are not covered by your healthcare.

_____ _____

PATIENT SIGNATURE DATE (per year)