

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES					
PATIENT NAME (<u>FIRST</u> – <u>MIDDLE INITIAL</u> -- <u>LAST</u>)			ADDRESS (<u>STREET</u> - <u>APT #</u> (if necessary) - <u>ZIP/POSTAL CODE</u>)		
CITY, STATE		EMAIL		HOME 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 <input type="checkbox"/> Other _____			LANGUAGES <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> Portuguese <input type="checkbox"/> Russian <input type="checkbox"/> French <input type="checkbox"/> Italian <input type="checkbox"/> Hebrew <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"/> Text <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"/> Current Patient _____ <input type="checkbox"/> Newspaper/Magazine (Which one?) _____ <input type="checkbox"/> Social Media (Which one?) _____ <input type="checkbox"/> Doctor _____ <input type="checkbox"/> Friend/Family Member _____ <input type="checkbox"/> Other _____					
PREFERRED PHARMACY (please include as much information as you can)					
PHARMACY NAME			ADDRESS		
CITY & ZIP		PHONE		CROSS STREETS/SHOPPING CENTER	
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"/> Fillers		<input type="checkbox"/> Hair Loss/Thinning		<input type="checkbox"/> Acne/Acne Scars/Rosacea	
<input type="checkbox"/> Botox		<input type="checkbox"/> Scar Revision		<input type="checkbox"/> Vitamins	
<input type="checkbox"/> Sclerotherapy (veins)		<input type="checkbox"/> Laser Hair Removal		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Peels/Facials		<input type="checkbox"/> Skincare Products		<input type="checkbox"/> 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)
Cancer (indicate type)			
Diabetes			
High Cholesterol			
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 Recovering Drug Addict

Yes No - Do you use tobacco? Smoke (___ packs per day) Chew Vape Former Tobacco User

Yes No - Do you use illicit drugs? If so, which ones/how often? _____

Yes No - Do you use medical marijuana? Smoke Edibles Medical Marijuana Card Holder

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/HOSPITALIZATION	APPROXIMATE DATE/YEAR

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 | <input type="checkbox"/> Other _____ |

PLEASE INDICATE REACTION: _____

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

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> NONE/No Known Medical History | <input type="checkbox"/> chronic fatigue syndrome | <input type="checkbox"/> menopause | <input type="checkbox"/> STD's _____ |
| <input type="checkbox"/> seasonal allergies | <input type="checkbox"/> depression | <input type="checkbox"/> kidney stones | <input type="checkbox"/> rheumatoid arthritis |
| <input type="checkbox"/> sinusitis/sinus conditions | <input type="checkbox"/> anxiety | <input type="checkbox"/> organ transplant _____ | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> arthritis conditions | <input type="checkbox"/> insomnia | <input type="checkbox"/> osteoporosis/osteopenia | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> asthma | <input type="checkbox"/> migraines/headaches | <input type="checkbox"/> anemia | <input type="checkbox"/> COVID-19 infection |
| <input type="checkbox"/> atrial fibrillation | <input type="checkbox"/> ADHD | <input type="checkbox"/> pneumonia | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> bleeding problems/disease | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> CAD, coronary artery disease | <input type="checkbox"/> alcohol abuse | <input type="checkbox"/> seizure disorder | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> cardiac arrest | <input type="checkbox"/> drug abuse | <input type="checkbox"/> tremors | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> pacemaker or defibrillator | <input type="checkbox"/> infertility | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> CHF, congestive heart failure | <input type="checkbox"/> ED, erectile dysfunction | <input type="checkbox"/> neuropathy | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> hypertension/high blood pressure | <input type="checkbox"/> hypothyroidism (slow thyroid) | <input type="checkbox"/> hernia (type) _____ | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> high cholesterol | <input type="checkbox"/> hyperthyroidism (hyper thyroid) | <input type="checkbox"/> onychomycosis (nail fungus) | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> pulmonary embolism | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> skin cancer (melanoma) | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> DVT, blood clot in legs | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> skin cancer (non-melanoma) | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> stroke | <input type="checkbox"/> IBS, irritable bowel syndrome | <input type="checkbox"/> acne | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> BPH (enlarged prostate) | <input type="checkbox"/> GERD, reflux disease | <input type="checkbox"/> psoriasis | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> UTI, urinary tract infection | <input type="checkbox"/> H. pylori disease | <input type="checkbox"/> eczema | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> diabetes, type I (insulin-dependent) | <input type="checkbox"/> diverticulitis/diverticulosis | <input type="checkbox"/> vitiligo | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> diabetes, type II | <input type="checkbox"/> celiac disease | <input type="checkbox"/> cancer _____ | |
| <input type="checkbox"/> gestational diabetes | | | |

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 contact (calls, emails, texts) regarding your care, test results, and appointments will be made to your preferred phone number and/or email address. 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, email, or text 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: _____

Practice Guidelines and Policies

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

_____ **Insurance, copayments, deductibles and coinsurance:** The practice will contact your insurance company in order to obtain verification and benefits. In the event that the benefits information given are different than what your insurance company pays, you will be responsible for the additional fees required. This may include all copayments, deductibles, coinsurances, or non-covered services. All payments are due at time of your visit. It is your responsibility as the patient to understand your insurance plan benefits.

_____ **Prescriptions:** To allow us to serve all our patients efficiently, the practice expects you to ensure you have enough medication to last until your next visit. If you run out of a prescribed medication, an office visit may be required. If this is not possible, the doctor may authorize a refill on your prescription for a one time courtesy. All current prescriptions require an office visit within 6 months and all new prescriptions require an office visit. All controlled substance prescriptions require an office visit.

_____ **Labs and Diagnostic Tests:** There is a convenience fee for collecting and processing your specimens and supplies in the office (blood draw). You may request at any time to go to the lab for your blood work (i.e., Quest and LabCorp). Most insurances cover outside lab collection at no additional charge. All abnormal labs and diagnostic tests require a follow up visit with the provider to go over the results and ensure continuity of care. No results will be given without an appointment unless directed by the physician. It is your responsibility to make a follow up appointment to review the results with your physician.

_____ **Convenience Fees:** Additional fees to perform tests including EKGs, urine testing, urine pregnancy testing, and other services. Additional charges apply for paperwork including but not limited to: immunization documents, biometric or wellness forms, and school/sports physical forms. The following fees start at \$30.00 and are subject to change without notice to forms.

_____ **Consent to Treat:** I understand that the physical examination during my visit with Dr. Fawn Winkelman at Elite Medicine and Aesthetic Institute may include a medically appropriate examination of my pelvic area should one be necessary, and I consent to such examination. I also understand that her staff will be present during this examination to assist at all times.

_____ **Emergencies:** The practice will make every effort to receive your calls and respond promptly. If you do not receive an immediate response, call 911 or seek the nearest emergency room.

_____ **Personal Injury:** The practice does not treat motor vehicle collision, personal injury, PIP, or worker's compensation patients.

Practice Guidelines and Policies

_____ **Virtual Visits:** The practice conducts optional virtual visits to include electronic communication of medical information using telephone, videoconferencing, electronic transmission of imaging/labs, and remote monitoring of vital signs as part of patient care. You as the patient agree to accept responsibility for conducting these visits in a private setting to maintain confidentiality of your protected health information (“PHI”).

_____ **Appointments:** The practice is respectful of your time and we ask you be respectful of ours. Please arrive 20 minutes prior to your appointment to register. Minors must be accompanied by a parent or guardian unless special arrangements have been made. All appointments are confirmed via phone call and/or text/email message. It is your responsibility to document your appointment.

_____ **Cancellations/Missed Appointments:** The practice will make every effort to accommodate patients. We understand that appointments may need to be changed. Please call at least **24-hours** in advance if you cannot keep your scheduled appointment to avoid a “no show” fee. A fee of **\$50.00** will be charged for non-cancelled or missed appointments (virtual and in person) which must be paid prior to your next appointment. For patients who are delayed and arrive late, every effort will be made to see them same day. If you are more than 15 minutes late, you may need to be rescheduled. A pattern of non-cancelled, missed, and/or late appointments may result in discharge from the practice.

_____ **Medical Records:** The medical record 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.

_____ **Statement Policy:** The practice 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. These delays may 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 90 days old.

_____ **Collection and Bank fees:** Accounts more than 90 days old are subject to an outside collection agency. You will be liable for all such expenses including collection fees, legal fees, and court costs. A returned check fee applies 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
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 _____

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

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

- | | |
|--|---|
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> ER Records |
| <input type="checkbox"/> Last Lab Report | <input type="checkbox"/> Hospital Records |
| <input type="checkbox"/> Last Wellness Visit | <input type="checkbox"/> X-Ray Reports/Images |

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/Fax Number _____

Address (Street, City, State and ZIP)

FROM:

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