PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

Date_____

Name _____ **Marital Status** S ☐ M ☐ D ☐W ☐SEP ☐ Date of Birth _____ Age ____

Patient Social Security #_____

Primary Language_____

Race & Ethnicity _____

Street Address_____ City, State, ZIP_____

Phone (Home)_____ (Work)_____ Occupation _____

E mail _____ (Cell)_____ Employer _____

Spouse's Name Date of Birth Occupation/Employer Phone

EMERGENCY CONTACT Phone Relationship

Referred by _____ Primary Doctor _____

Phone (if known)_____ Phone (if known)_____

Fax (if known)_____ Fax (if known)_____

INSURANCE & BILLING INFORMATION

Payment Required At Time of Service Unless Prior Arrangements Have Been Made

1) PRIMARY INSURANCE COMPANY I.D.#_____GROUP #_____

_____ Co-Pay $_____

2) SECONDARY INSURANCE COMPANY I.D.#_____GROUP #_____

ASSIGNMENT OF INSURANCE BENEFITS

I herby authorize direct payment of surgical/medical benefits to **Dr. Richard Kimmel** for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize **Dr. Richard Kimmel** to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICARE/MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original

PATIENT (please print)_____Date_____

PARENT/GUARDIAN (please print)_____SIGNATURE_____

THE BOCA VEIN CENTER
SCREENING

Name: _____Date: _____
Home Phone:_____ Cell Phone: _____Zip Code: _____
E-Mail _____ Health Insurance: _____

1. I am concerned about : Check all that apply:

Spider veins ____ Bulging Varicose Veins ____ Leg Swelling ____
Other:_____

2. Do your veins limit your daily activities due to discomfort? Yes ☐ No ☐

3. Does prolonged sitting or standing aggravate your veins? Yes ☐ No ☐

4. Have you ever noticed any of the following occur during activity or after prolonged standing? Check all that apply:

aching ☐ fatigue ☐ swelling ☐ itching ☐ cramps ☐

heaviness ☐ pain ☐ throbbing ☐ burning ☐ restless legs ☐

ulceration phlebitis ☐ skin changes ☐ discoloration ☐

pelvic congestion ☐ exercise intolerance ☐ blood clot ☐

bleeding from spider veins ☐ spontaneous bruising ☐

5. Have you attempted to manage your varicose vein symptoms in the past using any of the following? Check all that apply:

Medications ☐ weight loss ☐ exercise☐ injection sclerotherapy ☐

Leg elevation ☐ surgery ☐ compression stockings ☐

Other _____

6. What do you want to achieve with your vein treatment? _____

_____

DR RICHARD D. KIMMEL

OFFICE PAYMENT POLICY

This office accepts Medicare assignment and **we will** submit your claim to Medicare for you. If there are any complications in obtaining payment, you are responsible.

There will be a $25.00 charge (or bank fee if greater than $25.00) for all returned checks.

There will be a $25.00 charge for any appointment that is cancelled without 24 hour notification to our office. There will be a $250.00 charge for any procedure that is cancelled without 48 hour notification.

If you have insurance other than Medicare and it requires a referral you must bring it with you on the day of your appointment, it is your responsibility to make sure you have a referral. If you do not have a referral form, you must consult with our office manager before seeing the doctor; otherwise, **you** may be responsible for immediate payment of the full amount of the services rendered. If there are any complications in obtaining payment, you the patient are responsible.

Copayments are **due at the time of service**. Credit cards are only accepted for amounts of $50 or greater. We accept Visa, MasterCard, cash or check.

If your account is referred to an outside agency for collection, you will be responsible for all collection, attorney and court costs. Interest will be added to all accounts turned over for collection.

I certify that I have read and understand fully these office policies and agree to make payment in full and/or satisfactory arrangements when asked to do so as specified above.

_____ _____

Signature of Patient Date

_____

Social Security Number

PRIVACY POLICY STATEMENT

Richard D. Kimmel, D.O., F.C.C.P., F.A.C.O.S.
9980 CENTRAL PARK BLVD.
SUITE 316
BOCA RATON, FL 33428
(561) 477-0210

We are required by Federal and State Law to maintain the privacy of your health information according to the HIPAA Act of 1996 (Health Insurance Portability and Accountability Act) A copy of our Notice of Privacy Practices is available to you upon request.

Consent and Acknowledgement of Notice

I hereby acknowledge that I have been offered a copy of this practice's Notice of Privacy Practices, and I authorize this office to use and disclose my health information for treatment, payment (billing my insurance company) and for healthcare operations.

Name of Patient:_____

Signed:_____**Date:**_____

Telephone:_____

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient
- ☐ Other: please state_____

For Office Use Only:

☐ Signed form received by_____

☐ Acknowledgement refused:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

PATIENT RELEASE OF INFORMATION

Richard D. Kimmel, D.O., F.C.C.P., F.A.C.O.S
9980 Central Park Blvd.
Suite 316
Boca Raton, FL 33428
(561) 477-0210

In order for our office to provide you with high quality care, it may be necessary that we be able to speak to family members or friends (designated by you) regarding your care. To protect your privacy we will only speak to those people you have listed. Please be advised that to avoid confusion and communication problems, designate only one individual as your **PRIMARY** contact person. If you do not want us to speak to anyone about your condition, check the box below.

_____	_____
Authorized person	Relationship
_____	_____
Authorized person	Relationship
_____	_____
Authorized person	Relationship
_____	_____
Authorized person	Relationship

☐ Do not speak to anyone regarding my condition.

We will not reveal any medical information about you to anyone who is not listed above, without your written authorization. This authorization may be revoked by you at anytime by calling our office at 561-477-0210.

_____	_____
Patient Signature	Date