PATIENT REGISTRATION_____Date_____

Name _____ **Marital Status** S/M/W/D/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. I understand that it is my sole responsibility to notify the office of any changes to 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. I also authorize the release of information to my credit card company or another 3rd party for reimbursement or if there are any disputed services.

INSURANCE PAYMENT

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_____

SIGNATURE_____

PRIVACY POLICY STATEMENT

KIMMEL INSTITUTE
1905 Clint Moore Road, Suite 215
Boca Raton, FL 33496
(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

KIMMEL INSTITUTE
1905 Clint Moore Road, Suite 215
Boca Raton, FL 33496
(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

_____
Patient Print Name

KIMMEL INSTITUTE
1905 Clint Moore Road, Suite 215
Boca Raton, FL 33496

OFFICE PAYMENT POLICY

Patient Name: _____Date: _____

Welcome to the Kimmel Institute. Please read and sign below to confirm that you understand and agree to our office payment policy.

Medicare . This office accepts Medicare assignment and we will submit your claim to Medicare for you. If you do not have a secondary then you will be responsible for the 20% that Medicare does not cover.

Insurance. You must present your insurance card at the time of your first visit and inform us of any changes to your insurance coverage before any treatment begins. Knowing your insurance benefits is your responsibility and you should contact your insurance company with any questions you may have about your coverage. All co-pays and deductibles will be collected at the time of your visit. If your insurance requires a referral we will work with you to obtain that, but it is ultimately your responsibility to get a referral. If you do not have a referral then any services you receive will ultimately be your responsibility.

Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Please be aware that the balance of your claim is your responsibility and your insurance benefits are a contract between you and your insurance company.

Non Covered Services. If you do not have insurance or we do not participate with your insurance plan, then all services must be paid for at the time of treatment. Please be aware that some services or products will not be covered by insurance and these must also be paid for in full at the time of your visit.

Cancellation Policy. Please note that that we have a 24 hour cancellation policy for regular office appointments. If you cannot make your appointment you must call the day before to cancel or you will be charged $25.00. Procedures require a significant amount of time on our schedule and require a 48 hour notice for cancellation or there will be a $250.00 charge.

Nonpayment. 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, as allowed by law.

It is your responsibility to inform our office of any address or telephone number changes so that your account may be kept current. If your insurance changes, you must notify us before treatment begins. We accept American Express, Visa and MasterCard with a minimum charge of $25.00. We also accept personal checks and cash as payment. There is a $25 charge for returned checks and a 5% processing fee for credit card refunds.

_____ _____

Patient Signature Date

KIMMEL INSTITUTE SCREENING

Name: _____ Date: _____
DOB:_____
Home Phone: (____)_____Cell Phone: ___)_____
E-mail: _____Health Insurance: _____

PLEASE TELL US HOW WE CAN HELP YOU BY CIRCLING ALL THAT APPLY

I AM INTERESTED IN LASER TREATMENTS FOR

- Hair removal/ reduction (which area) _____
- Hyperpigmentation-IPL (intense pulsed light)
- Stretch Mark Revision
- Laser vein treatment
- Scar Revision
- Fractional Non-Ablative Skin Resurfacing
- Photo Facial Rejuvenation

I AM INTERESTED IN VEIN TREATMENTS FOR

•Spider Veins • Bulging Varicose Veins • Leg Swelling •Other _____

1. Have you ever noticed any of the following symptoms in your legs during activity or after prolonged standing? Circle all that apply.

aching	fatigue	swelling	itching	cramps
pain	throbbing	burning	restless legs	ulcerations
discoloration	blood clots	heaviness	skin changes	phlebitis
spontaneous bruising	exercise intolerance		bleeding from veins	

2. Have you attempted to manage your vein symptoms in the past using any of the following? Circle all that apply.

Medications	weight loss	exercise	injection sclerotherapy
Leg elevation	surgery	compression stockings	

Other _____

I AM INTERESTED IN AESTHETIC TREATMENTS

Obagi Skin Care	Sculptra		
Botox	Dysport	Juvederm	Restalyne
Radiesse			
Belotero	Xeomin	Perlane	Blue Peel
Blue Peel Radiance			

_____ I would like a consultation to discuss what treatments are right for me.

1905 Clint Moore Road, Suite 215, Boca Raton, FL 33496 Phone (561) 477-0210
Fax (561) 470-0198 www.thekimmelinstitute.com

Medications, Vitamins and Supplements

Patient Name:_____Date:_____

Allergies:_____

_____

Medication Name Dosage
Frequency

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____