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) - ZIP/POSTAL CODE)

CITY, STATE	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 ❑ Other _____

LANGUAGES ❑ English ❑ Spanish ❑ Creole ❑ Portuguese ❑ Russian ❑ French ❑ Italian ❑ Hebrew ❑ 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 ❑ Text ❑ 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?) _____ ❑ Social Media (Which one?) _____

❑ Doctor _____ ❑ Friend/Family Member _____ ❑ 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?

- ❑ Anti-aging
- ❑ Fillers
- ❑ Botox
- ❑ Sclerotherapy (veins)
- ❑ Latisse for eyelashes
- ❑ Hair Loss/Thinning
- ❑ Scar Revision
- ❑ Laser Hair Removal
- ❑ Micro-needling/PRP
- ❑ Peels/Facials
- ❑ Skincare Products
- ❑ Non-Surgical Fat Loss
- ❑ Acne/Acne Scars/Rosacea
- ❑ Vitamins
- ❑ 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

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**

❑ Wheat	❑ Adhesive Tape	❑ Penicillin	❑ Other _____
❑ Dairy Products	❑ Latex	❑ Aspirin	❑ Other _____
❑ Codeine	❑ Morphine	❑ Sulfa Drugs	❑ Other _____
❑ Anesthesia	❑ Iodine/Contrast Dye	❑ Shellfish	❑ Other _____

PLEASE INDICATE REACTION: _____

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

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

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 SCREENINGS	**DATE LAST PERFORMED**
Mammogram or Breast Ultrasound (breast cancer)	
Pap Smear (cervical cancer)	
Colonoscopy or Cologuard (colon cancer)	
Chest X-Ray	
PSA Level in Blood or Exam (Prostate)	

IMMUNIZATIONS/VACCINATIONS	**DATE PERFORMED**
COVID-19 vaccine (indicate all dates and type)	
Influenza/Flu	
TdaP (Tetanus Diptheria Pertussis)	
Pneumonia	
Shingles	
Others: Meningitis, Hepatitis, HPV, RSV	

PREVENTATIVE SCREENING	**DATE LAST PERFORMED**
Annual Wellness Visit with Blood Panel	
Annual EKG or Cardiac Tests, if necessary	
STD Check / HIV Check / Hepatitis Check	
Annual Eye Exam	
Annual Dental Exam	
Annual Derm or Skin Cancer Exam	
Foot Exam (for Diabetics)	
Osteoporosis Screening (bone density)	
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 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:_____

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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 $20.00 convenience fee for collecting 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 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.

_____ **Convenience Fees:** Additional fees to perform tests including EKGs ($50.00), urine testing ($25.00), urine pregnancy testing ($25.00), 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 $25.00 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.

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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.

_____ **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:** 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 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.

A. Notifier: see chart

B. Patient Name: **C. Identification Number: see chart**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **Dr. Winkelman's** services below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for **Dr. Winkelman's** services below.

D. Procedures, Tests, Services:	E. Reason Medicare May Not Pay:	F. Estimated Cost:

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive **Dr. Winkelman's** services listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want **Dr. Winkelman's** services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want **Dr. Winkelman's** services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want **Dr. Winkelman's** services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay**.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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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:

- ☐ 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/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 _____

Health Care Advance Directives

I, _____
have created the following Advance Directives:

___ Living Will

___ Health Care Surrogate Designation

___ Anatomical Donation

___ Other (specify) _____

---------- FOLD ----------

Contact:
Name _____

Address _____
_____
_____

Phone _____

Signature _____ Date _____