PATIENT REGISTRATION & HEALTH QUESTIONNAIRE Date_____

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

Primary Language_____Race & Ethnicity _____

Street Address_____ City, State, ZIP_____

Phone (Home)_____ (Work)_____ Occupation _____

E mail _____ (Cell)_____ Employer _____

_____

Spouse's/Significant other Date of Birth Phone

EMERGENCY CONTACT_____Phone_____ Relationship_____

Referred by _____ Primary Doctor _____

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 me 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

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_____

PATIENT SIGNATURE_____

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

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 $50.00 charge (or bank fee if greater than $25.00) for all returned checks.
There will be a $50.00 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.
Pt initials: _____

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, Discover, Amex cash or check. We charge a 3% surcharge for all credit card payments.
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**

PRIVACY POLICY STATEMENT

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:_____

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

PATIENT RELEASE OF INFORMATION

In order for our office to provide you with high quality care, it may be necessary that we be able to speak to family member 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 was us to speak to anyone about your condition, initial below.

_____ _____

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 abov, without your written authorization. The authorization may be revoked by you at anytime by calling our office at 561-477-0210.

_____ _____

Patient Signature **Date**

Social Media Consent / Release Form

For News Media, Promotional Materials, Written Articles, Research and / or Photographs.

I _____ hereby authorize The Kimmel Institute to use my photo and / or information related to my experiences with Dr. Kimmel and / or The Kimmel Institute. I understand this information may be used in publications, including electronic publications, audiovisual presentations, promotional literature, advertising and media and / or other similar ways.

My consent is freely given as a public service to Dr. Kimmel, without expecting payment.

I release Dr. Kimmel and The Kimmel Institute and their respective employees, officers and agents from any and all liability which may arise from the use of such news media stories, promotional materials, written aticles, videotape and / or photographs.

I Prefer that:

☐ My complete name be used

☐ My first name only be used

☐ No name be used

I understand that I can revoke this release any time in writing and that the use of any of my photos or other information authorized by this release will immediately cease.

_____

Name

_____

Signature **Date**

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

MEDICATIONS

Patient Name:_____ Date:_____

Allergies:_____

Pharmacy Name and Number:_____

MEDICATION NAME	DOSAGE	FREQUENCY