Kevin M Sattele, MD

Circle one

Name_____ **MI**_____ **Age** _____ **DOB**_____ **Male/Female**

Address _____ **City** _____ **State**_____ **Zip Code**_____

Home Phone _____ **Cell Phone** _____**Work Phone**_____

***Best Number to Reach** _____ **Occupation**_____

Email _____ by providing us your cell number and email address, you agree to communications including confidential medical information, appointment reminders and promotions sent to this cell/email address. (message/data rates may apply)

Please circle how you heard about our office? Circle all that apply. Friend Magazine Radio Billboard
Please elaborate _____

What helped you choose our office? _____

Medical History: (Circle all that apply)

Diabetes	Diabetic Retinopathy	Heart Disease	Stroke	Cancer	Arthritis
Lupus	Pancreatic Disease	Infections	Kidneys	Anxiety	Depression
Anemia	Thyroid Cancer	Bones	Circulation	Leukemia	Bleeding
Seizures	Thyroid Disorder	Fainting	Hernias	Blood Clot	HIV/AIDS
Hepatitis	Liver Disease	Lung Disease	Asthma	Insomnia	Skin Cancer
Keloids	Myasthenia Gravis	Multiple Sclerosis	Migraines	Blood Pressure	

_____

_____

Medications: (Please list ALL medications and/or vitamins you are currently taking)

_____

_____

_____

Allergies: (Circle all that apply)

Lidocaine Penicillin Sulfa Drugs Betadine Adhesives Latex
Other: _____

_____

_____

Surgical History: (Circle all that apply)

Hernia Hysterectomy Gastric Bypass Heart Bypass Heart Valve
Thyroid Abdominal Other:_____

_____

Primary Physician_____ **Phone Number**_____

Pharmacy_____ **Phone Number**_____

Have you ever had a substance abuse problem? _____ If yes, what type of substance _____

Do you smoke? _____ Alcohol? _____ How Often? _____

Are you pregnant? _____ Are you planning to get pregnant? _____

Receptionist will need a copy of a valid state issued driver's license.

Signature_____ Date_____

Dr. Sattele's
Rapid Weight Loss
& Esthetics Centers

Notice of Privacy Practices
Effective Date: [2006]

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Your Rights

You have the right to:

- Get a copy of your medical record
- Correct your medical record
- Request confidential communications
- Ask us to limit what we use or share
- Get a list of those with whom we've shared information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You can tell us your choices about:

- Sharing your information with your family, close friends, or others involved in your care
- Sharing information in a disaster relief situation
- Including your information in a hospital directory
- Contacting you for fundraising efforts

If you have a clear preference for how we share your information, tell us what you want us to do, and we will follow your instructions where legally allowed.

Our Uses and Disclosures

We typically use or share your health information in the following ways:

- **Treat you:** We can use your health information and share it with other professionals who are treating you.
- **Run our organization:** We can use and share your information to run our practice, improve your care, and contact you when necessary.
- **Bill for your services:** We can use and share your information to bill and get payment from health plans or other entities.

Other ways we may use or share your information:

- Public health and safety issues
- Research (under strict conditions)
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, or other government requests
- Respond to lawsuits and legal actions

Our Responsibilities

We are required by law to:

- Maintain the privacy and security of your protected health information
- Inform you promptly if a breach occurs that may have compromised the privacy or security of your information
- Follow the duties and privacy practices described in this notice
- Provide you with a copy of this notice

We will not use or share your information other than as described here unless you give us written permission. You may revoke permission at any time.

For More Information or to Report a Problem

If you have any questions about this notice, or if you believe your privacy rights have been violated, please contact our Compliance Officer: **Kelly Sattele** 843-662-1515. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You will not be retaliated against for filing a complaint.

Name of Patient or Legal Representative: _____

Signature of Patient or Legal Representative: _____ Date: _____

Dr. Sattele's Rapid Weight Loss & Esthetics Center

Authorization of Medical Treatment

I hereby authorize the responsible physician, Kevin M. Sattele, M.D. and his associates at Dr. Sattele's Rapid Weight Loss & Esthetics Center to provide any medical treatment, which in their judgment is deemed proper and medically necessary. I understand Dr. Sattele may prescribe medications to be used "off label" and I have the opportunity to ask any questions to clarify any areas I do not understand regarding any use of 'off label" medications/treatments given.

_____ _____

Print Patient's Name Date of Birth

_____ _____

Patient, Guardian or Legal Representative's Signature Date

Consent to Release Protected Health Information for Treatment, Payment, and Healthcare Operations

I hereby authorize the responsible physician, Kevin M. Sattele, M.D. and his staff members at Dr. Sattele's Rapid Weight Loss & Esthetics Center to release my personal protected health information for treatment of my health condition to any other physician or healthcare provider directly or indirectly involved in my care and treatment. Direct involvement example: a specialist or hospital to which Dr. Kevin M. Sattele has referred me to. Indirect involvement examples: a laboratory, physicians of radiology or pathology.

I understand that Mental Health, Substance Abuse, and HIV/AIDS related treatment will require an additional release of information authorization, each time the information is requested for treatment purposes, except in any emergency treatment situation, as this is Dr. Kevin M. Sattele's office policy.

I understand that Dr. Sattele's Rapid Weight Loss & Esthetics Center will make all attempts to protect my confidential protected health information at all times. When the practice discloses my information it will be to "Need to Know" personnel and the "Minimal Amount of Necessary Information" to accomplish the purpose will be provided including for the purpose of billing, payment, and collections.

I understand that I can request at anytime an accounting of disclosure (release of information) for treatment, payment, or healthcare operations, as of the start date of April 14, 2003, for disclosures made after this date.

I hereby consent and authorize Dr. Sattele's Rapid Weight Loss & Esthetics Center to use my protected health information for healthcare operations, such as quality assurance, improvement, and healthcare oversight as required by federal and state laws.

I understand that I may revoke this consent in writing at any time.

_____ _____

Print Patient's Name Date of Birth

_____ _____

Patient, Guardian, or Legal Representative's Signature Date

Physician-Patient Private Contract ("Agreement")

(Medicare Opt-Out)

Even though you, the patient, and I, the physician, are entering into a private agreement outside of Medicare, because I have opted out of Medicare, Medicare REQUIRES your agreement to the following terms MEDICARE HAS SPECIFIED, before we can proceed. This Agreement protects Medicare from payment responsibility for services you receive directly from me. If requested by Medicare, this Agreement will be provided to resolve any misunderstanding and clarify our intent. This Agreement must be signed before I can see you as a patient. Please review the following and sign this Agreement to confirm your acceptance of the terms of this Agreement:

The undersigned patient/Medicare beneficiary (or the Medicare beneficiary's legal representative) (either is referred to as "Medicare Beneficiary") is signing this Private Contract to evidence his or her understanding and agreement regarding payment for any services to be provided by Dr. Kevin M. Sattele, M.D. ("Physician"). Physician's practice entity is known as Dr. Sattele's Rapid Weight Loss & Esthetics Centers (also referred to as "Physician"). Physician hereby certifies that Physician is not and has not been excluded from participation in the Medicare program under section 1128 or other applicable sections of the Social Security Act.

Physician further certifies that the effective date of Physician's opt-out is 05/04/2026, and the opt-out period estimated is 05/04/2028.

By executing this Private Contract, Medicare Beneficiary acknowledges and agrees as follows with respect to all items or services provided by Physician to Medicare beneficiary:

1. That Medicare Beneficiary will not submit a claim, or request Physician to submit a claim, for payment under Medicare, even if such items or services would otherwise be covered under Medicare.
2. That Medicare Beneficiary agrees to accept full responsibility for payment in full at the time of service, in accordance with Physician's current fee schedule (see over), whether Medicare Beneficiary is reimbursed through private insurance or otherwise, for payment for all such items or services.
3. Medicare Beneficiary understands that NO reimbursement can or will be provided by Medicare for such items or services provided by Physician.
4. That Physician is not limited by Medicare in the amount that he or she may charge Medicare Beneficiary for the items or services provided, and that Medicare Beneficiary will pay Physician's charges in full at time of service.
5. That Medigap plans do not make payment, and other Medicare supplemental insurance plans may choose not to make payment, for items or services furnished by Physician.
6. That Medicare Beneficiary has the right to have the items or services sought from Physician to be provided by other physicians or practitioners whose items or services would be covered by Medicare.
7. That Medicare Beneficiary is not in an emergency or urgent health care situation.
8. That Medicare Beneficiary agrees to reimburse Physician for any costs, collection fees, and reasonable attorney's fees that result from violation of this Agreement by Medicare Beneficiary.
9. That Medicare Beneficiary acknowledges a copy of this Agreement has been provided to Medicare Beneficiary.
10. That Medicare Beneficiary signs this Private Contract voluntarily and upon full understanding of its terms.

Effective start and end date of opt out: 05/04/2026 to 05/04/2028.

Date: _____

Patient/Medicare Beneficiary (or Legal Representative): _____

If Representative, Print Name and Relationship: _____

Physician:

_____

Kevin M. Sattele, M.D