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 email you agree to communications including confidential medical information, appointment reminders and promotions sent to this email address).

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_____ ___

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