



Neil J. Zimmel, MD
Certified American Board of Plastic Surgery

14051 St. Francis Blvd., Suite 2209
Midlothian, VA 23114
p: 804.423.2100 • fx: 804.423.2102
www.drzimmel.com • drzimmel@drzimmel.com

PLEASE COMPLETE ENTIRE PACKET PATIENT INFORMATION

Confidential Information: *The information herein will not be released except when you have authorized us to do so. This information will be used by the doctors in their decisions regarding your care.*

Today's date:

Patient's Name:

Address: _____

City: _____ State: _____

ZIP: _____

Telephone Numbers: Home: _____ Cell: _____ Work: _____

E-mail address: _____ Date of Birth: _____

Age: _____ Height: _____ Weight: _____ Male Female

Marital Status: Single Married Widowed Divorced Separated

Social Security Number:

Emergency Contact Name:

Telephone: Home: _____ Cell: _____ Work: _____

Employer (if patient is a minor, parent's place of employment):

Employer Address:



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Telephone:

**Family Physician's
 Name:**

**Medical Insurance
 Company:**

Policy Number _____ Group
 Number _____

Primary Policyholder's Name _____ Primary Policyholder's Birth
 date _____

Your health is of extreme importance to us. The more we know about you, the better we can assist you. Please complete the information on the following pages as completely as possible.

What brings you to our office? Please be as specific as possible.

How long has this concerned you?

Have you had any previous treatment for this?

If YES, how and when was this treated?

Review of systems:

Do you have or have you had any of the following? *(Please check yes or no)*

	YES	NO		<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>
			Asthma	<input type="checkbox"/>	<input type="checkbox"/>



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Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Back problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots in legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>
Nose/throat problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear/eye problems	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
		YES	NO	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transfusion	<input type="checkbox"/>	<input type="checkbox"/>

Past Medical History:

List all medical conditions and any major hospitalizations and including dates:

Past Surgical History:

List all Past Surgical Procedures including dates:

Are you allergic to or have you ever had a reaction to any medication or drug, local anesthetic, or general anesthetic? If so, please list medication and type of reaction:

What medications to you take regularly? (aspirin, birth control pills, herbs, vitamins, etc.)?



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Do you have a problem with excessive scarring or keloid formation after being cut? Yes No

Is your general health good? Yes No

Have you ever had psychiatric problems, a nervous breakdown or been under the care of a psychiatrist, psychologist or mental health counselor? Yes No

If so, please list what condition you have been treated for.

Family History:

Do you have any diseases or conditions that run in your family? If yes, please list condition and explain which family member is affected. _____

Have you or a member of your family ever had a problem with anesthesia? Yes No If Yes, please Explain _____

Social History:

What is your profession? _____

Do you currently smoke? Yes No

If yes, how many packs per day _____ For how many years?

Have you ever smoked? Yes No



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If yes, how many packs per day? _____ For how many years?

Do you drink alcohol? Yes No
If yes, how much? _____

How often?

Please list all of your doctors. Please include primary care physicians, specialists, and mental health care professionals.

How did you learn about us? (Please check all statements that apply.)

- _____ A Friend referred me to Dr. Zimmel (name) _____
- _____ A doctor referred me to Dr. Zimmel (name) _____
- _____ I visited your web site.
- _____ I saw an ad in a magazine or newspaper.

Thank you for taking the time to complete this information.

I certify the above to be true to the best of my knowledge.

Patient (or legal guardian)
Date

Reviewed by Physician

Date



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WRITTEN ACKNOWLEDGEMENT FORM OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose Private Healthcare Information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I, _____ have read and/or received a copy of the Notice of Privacy Practices of Neil J. Zimmel, MD, PC and Richmond Aesthetic Surgery.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to Neil J. Zimmel, MD, PC and Richmond Aesthetic Surgery if I do not understand any information contained in the Notice of Privacy Practices.

Patient (or patient's legal guardian)

Date

Witness



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RELEASE OF MEDICAL INFORMATION

I authorize to any holder of medical or other information about me to release to my insurance carrier any information needed for this or any related claim.

I hereby authorize, request and assign payment directly to Neil J. Zimmel, MD, PC d/b/a Richmond Aesthetic Surgery for bills rendered by this office covering Dr. Zimmel's services and any past and future treatments if related to the incident or condition giving rise to these services by all insurance carriers with whom I have coverage or settlements or judgments flowing from the incident for which I am receiving treatment. This authorization shall include all benefits specified and/or master medical benefits otherwise payable to me.

I permit a copy of this authorization to be used in place of the original.

Patient (or patient's legal guardian)

Date

Witness



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PATIENT CONSENT TO TREATMENT

Please read each section carefully. You may request a copy of this form for your own records.

Patient name: _____

I, the undersigned, do hereby request and consent to an evaluation and treatment by Dr. Neil J. Zimmel. I wish to rely on Dr. Neil J. Zimmel to exercise judgment for my best interest me or that of my dependent, the above-named patient, during the course of treatment. I will inform Dr. Neil J. Zimmel or his assistant who is treating me or my dependent of any sensitive areas or adverse conditions that I or my dependent may have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment.

I clearly understand and agree that all services rendered to me or to my dependent, the above-named patient, may be charged directly to me and that I am personally responsible for full payment. I understand that even if I suspend or terminate treatment, any fees for professional services rendered to me or to my dependent up to the point of termination will be immediately due and payable.

I acknowledge that Dr. Neil J. Zimmel and Richmond Aesthetic Surgery participates directly with several insurance plans (including managed care plans and Medicare) and that I am responsible for any outstanding fees for services provided to me or to my dependent, the above-named patient, by Dr. Neil J. Zimmel and/or Richmond Aesthetic Surgery that are not reimbursed through insurance or other third party payers; this includes all co-payments, deductibles, and out of pocket costs. I understand that a potentially refundable deposit to cover fees for uncovered services may be required at the time of service or follow-up.

For cosmetic procedures, I understand that I will be responsible for all facility and anesthesia fees incurred for subsequent revision and/or emergency procedures performed on me or my dependent, the above named patient, as well as necessary supplies including but not limited to implants, unless otherwise specified by Dr. Neil J. Zimmel. Any surgeon's fee that may be incurred for subsequent revision and/or emergency procedures will be addressed on a case by case basis.



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I authorize Richmond Aesthetic Surgery to submit all precertifications and claims directly to the insurers on my behalf. I hereby authorize the release of my medical records and other information necessary to process insurance claims. I understand and agree that any and all monies received from insurance companies and/or other third party payers as reimbursement for services rendered to me or to my dependent, the above-named patient, by Dr. Neil J. Zimmel and/or Richmond Aesthetic Surgery shall be forfeited in full to Dr. Neil J. Zimmel and Richmond Aesthetic Surgery. Any other arrangements that may involve insurance billing, reimbursement, payment plan, or payment deferral, must be made in writing with the office manager and/or Dr. Neil J. Zimmel. Verbal agreements are not acceptable.

Relationship to Patient: _____

Signature: _____

Date: _____



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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

YOU MUST PROVIDE YOUR INSURANCE CARD AND PICTURED IDENTIFICATION TO THE RECEPTIONIST FOR PHOTOCOPYING AT EACH APPOINTMENT. IN THE EVENT THAT NO INSURANCE IS AVAILABLE, OR IT HAS BEEN DETERMINED THAT THE PATIENT IS INELIGIBLE FOR COVERAGE OF SERVICES, THIS ACCOUNT WILL BE DETERMINED TO BE SELF-PAY AND PAYMENT IN FULL IS DUE AT THE TIME OF EACH SERVICE.

I hereby authorize Richmond Aesthetic Surgery to release medical information to my physicians and/or insurance company(ies). I further authorize direct payment from my insurance company(ies) to Richmond Aesthetic Surgery.

I understand that I am responsible for obtaining all necessary referrals prior to the scheduled appointment. All co-payments required by my insurance plan will be paid at the time of service. I further acknowledge that all deductibles, co-insurance and non-covered items as determined by my insurance plan will be due and payable upon notice either sent by U.S. mail in the form of a statement and/or telephone communication from Richmond Aesthetic Surgery.

After the first missed appointment without 24-hour notice given to Richmond Aesthetic Surgery, I will be responsible for a \$50.00 No Show fee.

All returned checks shall be assessed a \$40.00 bank processing fee, for which I will be responsible.

I acknowledge that a 1.5% per month interest charge may be added to any balance unpaid after 90 days of aging. I further acknowledge that I will be held responsible for any and all expenses incurred by Dr. Neil J. Zimmel and/or Richmond Aesthetic Surgery for a 30% collection fee and/or a 30% attorney fee on any balance referred to an attorney for collection as a result from my delay in payment for services rendered by Dr. Neil J. Zimmel and/or Richmond Aesthetic Surgery.

I further agree that if this account is not paid when due I will be responsible for a collection expense of 35% on the balance, plus any court costs incurred by Richmond Aesthetic Surgery, in addition to interest accrued after the initial 90 days of debt at 1.5% monthly.

Richmond Aesthetic Surgery reserves the right to assess a charge for telephone calls when medical care is dispensed in lieu of an office visit.



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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT
(Continued)

Patient (or patient's legal guardian)

Date