THE
ROXBURY
INSTITUTE
SCIENCE ART HEALTH BEAUTY

Welcome to The Roxbury Institute

We are honored you have chosen us for your care. Our goal is to provide the highest quality care and exceed your expectations during your visit. We respect your time and will do whatever we can to stay on schedule.

We realize that circumstances may keep you from your scheduled appointment, but we ask that you arrive on time. If you arrive more than 15 minutes late, we may need to reschedule you to a later time or date. This allows us to give each patient our undivided attention. If you must cancel or reschedule your appointment, kindly notify us within 24 hours of your appointment.

Our team is comprised of expert care providers offering specialized, yet integrated, approaches to care in the areas of lipedema treatment, regenerative medicine, anti-aging, nutrition and aesthetic procedures. We welcome any questions you may have about our integrated service offerings. For your convenience, if you would like to discuss any of the following during your visit, please check the respective section(s):

☐ Cosmetic Dermatology (fillers, wrinkle relaxers, microneedling, facials, etc.)

☐ Cosmetic Dentistry (veneers, teeth whitening, etc.)

☐ Body Contouring (liposuction, cellulite reduction, fat transfer, lipedema treatment, etc.)

☐ Regenerative Medicine (Stem cell therapy, IV and Vitamin therapy, internal wellness, etc.)

☐ Facial Plastic Surgery (rhinoplasty, face and neck lift, etc.)

Patient Name PRINT: ____

Patient (or Personal Representative) Signature: ______________________________________ Date: __________

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New Patient Information

NAME		DATE OF BIRTH	I IDENTIFY AS ☐ Male ☐ Female
STREET ADDRESS	CITY	STATE	ZIP CODE
BEST PHONE NUMBER ( ) - ☐ Cell ☐ Home ☐ Work	May we leave personal information on this phone? ☐ Yes ☐ No	ALTERNATIVE PHONE NUMBER ( ) - ☐ Cell ☐ Home ☐ Work	May we leave personal information on this phone? ☐ Yes ☐ No
EMAIL		May we contact you for the following? ☐ Appointment Reminders ☐ Special Offers and Updates ☐ Medical Information	
INSURANCE NAME	POLICY NUMBER	GROUP NUMBER	PATIENT RELATIONSHIP TO INSURED
PRIMARY CARE PHYSICIAN		PHYSICIAN PHONE	
PHYSICIAN STREET ADDRESS	CITY	STATE	ZIP CODE
EMERGENCY CONTACT NAME	PHONE NUMBER	RELATIONSHIP	
PHARMACY NAME			
PHARMACY STREET ADDRESS	CITY	STATE	ZIP CODE

How did you hear about us: ☐ Friend/Family ☐ Physician Referral ☐ Print ☐ Radio ☐ Television ☐ Website

¨ Social Media ☐ Public Event ☐ Insurance Carrier

¨ Other: ____

Authorization to share patient information

Name: ____
LAST FIRST MIDDLE

Date of Birth: _____________________

Phone Messages

Is there a phone number where The Roxbury Institute can and leave detailed messages regarding your care, appointment/health screening reminders and other health care messages?

☐ Yes ☐ No

If yes, please provide phone number: ______________________________

Test Messages

Do you wish to receive appointment/ health screening reminders and other health care messages via text?

☐ Yes ☐ No

E-Mail

Do you wish to receive appointment/ health screening reminders and other health care messages via e-mail?

☐ Yes ☐ No

If yes, please provide preferred e-mail address:____

Additional Contact

Is there someone else who The Roxbury Institute can leave detailed messages with and share your patient information?

☐ Yes ☐ No

If yes, please provide:

Name: __________________________________Relationship to Patient: ____________________________________

Phone: __________________________________

I hereby consent to receiving messages as indicated above from The Roxbury Institute and its affiliates. These parties may use the provided information to contact me by e-mail, live agent, voice mail, text message or pre-recorded message, including by using an auto-dialer or other computer assisted technology, or by any other electronic communication for purposes that include appointment and follow-up health care reminders, pre-registration, surveys, prescription information, health-related products or

services that may be of interest, my account(s), assignment of benefits, and financial responsibility. I understand that depending on my phone plan, I could be charged for these calls or text messages. I also understand that providing this contact information and consent are not conditions to receiving health care services. With respect to text messages, I understand that I can opt-out at any time by replying "STOP" to the text message from my mobile device.

This Authorization to Share Patient Information remains in effect until a request to withdraw this form is submitted in writing by the patient.

Patient Signature: ___________________________________ Date: _________________ Time: ________________

If signed by other than patient, indicate legal relationship to patient: ____

Acknowledgment of receipt of notice of privacy practices

I understand that The Roxbury Institute ("TRI") including Roxbury entities, may share my health information for treatment, billing and healthcare operations. I have been provided a copy of TRI's Notice of Privacy Practices that describes how my health information is used and shared. I understand that TRI has the right to change this notice at any time. I may obtain an additional copy by visiting the website at www.theroxburyinstitute.com.

I acknowledge receipt of the Notice of Privacy Practices of The Roxbury Institute:

Patient Name: ____

Signature: ____ Date: _______________________
PATIENT/PARENT/ CONSERVATOR/ GUARDIAN

If singed by other than patient, indicate relationship to patient: ____

INABILITY TO OBTAIN ACKNOWLEDGMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reasons why the acknowledgment was not obtained.

Reasons why the acknowledgment was not obtained:

☐ Patient or Legal Representative received Notice of Privacy Practices but refused to sign Acknowledgment of Receipt

☐ Patient or Legal Representative unavailable to acknowledge receipt of Notice of Privacy Practices

☐ Other: ____

Patient Name: ____

TRI Staff Signature: ____ Date: ___________________

Patient Financial Responsibilities

Thank you for choosing the providers at The Roxbury Institute. We ask that you read this form to acknowledge your understanding of our patient financial policies.

No-Show Fee (Please Initial)

- _____Existing patients who do not show up for the appointment or do not cancel 24 hours prior, will be charged a $150 no-show fee.

Cosmetic Procedures and Surgery

- Cosmetic procedures and surgery is not a benefit that is paid by most health insurance plans. We expect full payment for these procedures either due on the day of service or on the payment schedule given to you by the patient care coordinator.
- There are no refunds for surgical or non-surgical procedures.

Insurance Coverage and Changes

- It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by your insurance carrier.
- We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of your visit, the financial responsibility for payment is yours.
- If you have had any changes in your insurance coverage - even if there is only a small change in the co-payment amount or a change in the expiration date of the policy - you must notify us. Even a small discrepancy on the chain form can lead to a claim denial.

Co-Payments, Co-Insurance and Deductions

- Co-insurance and co-payments are the patient's responsibility. Co-pays are due at the time of visit.
- Deductibles are patient's responsibility. The deductible is determined by the contract you have with your insurance carrier. We do not know how much each person's deductible is and how much has been met at the time of your visit.
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Insurance Payments

- If insurance payments are sent to you, you are responsible for forwarding them to our office with a copy of the explanation of Benefits (EOB) received.
- You are responsible for responding to any request from the insurance company for further information. Not doing so will result in a claim denial and you will be responsible for payment.

Labs

- If you are aware that your insurance carrier requires you to utilize certain labs for blood work or biopsies, it is your responsibility to inform our office prior to the lab being performed. Our office sends your insurance card information with the specimen to an outside facility. Lab charges are separate charges from our office charges.

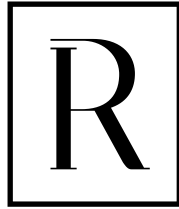
Non-Covered Service

- All patients are responsible for "non-covered" services if denied by their insurance carrier.

I have read and understand this financial responsibility form:

Patient Name PRINT: ____

Patient (or Personal Representative) Signature: ______________________________________ Date: __________



THE ROXBURY INSTITUTE

Consent for Photography, Video and/or Audio Recordings

By signing this document, I give permission for The Roxbury Institute, Providers and Staff to take before and after photos and/or video of me that pertain to my treatment. The purpose of taking photos and videos is to track the progress of my treatment and use these materials in my medical records, for marketing or promotional efforts, and/or for educational purposes such as medical teaching or publication in medical textbooks or journals. **The materials will not contain my name, face, or any other personal identifying information.**

At my request, I can have access to view the materials or obtain copies, but I must notify The Roxbury Institute in writing if I no longer wish these materials to be used for the purposes granted by this consent form. I understand that these materials will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law.

________ I give consent for my photos to be used on website and social media. (All identifying markers will be blurred or blacked out to hide your identity)

________ I give permission for filming and photographs to be taken in the OR if I have a surgical procedure.

________ I give consent for my photos to be used internally to show doctors and patients results of the treatments performed.

________ I do not want my photos used for any purpose other than my personal record.

____

Patient or Guardian Print Name　　Signature　　Date

____

Witness Print Name　　Signature　　Date

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