Orit Markowitz MD.
1150 Fifth Avenue, Suite 1A • New York, NY 10128
Tel: (212)828-3120 • Fax: (914)502-4846
www.optiskinmedical.com

PATIENT REGISTRATION FORM:

LAST NAME:_____ FIRST NAME:_____ MI INITIAL:_____

STREET ADDRESS:_____ APT:_____

CITY:_____ STATE:_____ ZIP CODE:_____

DATE OF BIRTH: _____/_____/_____ AGE: _____ SEX: M/F SSN# _____

EMAIL: _____ OCCUPATION: _____

HOME NUMBER: (_____)_____ WORK: (_____)_____ CELL : (____)_____

EMERGENCY CONTACT: _____ PHONE NUMBER: (____)_____

PHARMACY NAME:: _____ PHONE NUMBER: (____)_____

PRIMARY CARE PHYSICIAN: _____ PHONE NUMBER: (____)_____

REFERRING PHYSICIAN: _____ PHONE NUMBER: (____)_____

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____

NAME OF POLICY HOLDER: _____

MEMBER ID: _____

How did you hear about us?

Referring Physician	Name of Physician:
Insurance company	
Magazine	
Facebook	
Instagram	
The Practice Website	
Friend/Family	

We participate with **Aetna, Cigna, Blue Cross and Blue Shield, Oxford, Empire, Medicare, and United Health Care;** we do not participate with any other insurance plans. **It is the patient's responsibility to obtain any referrals needed prior to appointment. If a needed referral is not provided for the day of service, the patient is the responsible party.**

PATIENT SIGNATURE: _____ DATE:_____

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Please let us know the reason for your visit:

_____

_____

_____

ADDITIONAL SERVICES

At Markowitz Medical we offer a variety of services including medical, cosmetic and laser. Please let us know what additional services you would like to learn about. Please check all that apply.

• Total Body Skin Exam • Non-Invasive Skin Cancer Laser Treatment • Photodynamic Therapy (PDT) • Skin Cancer Surgery • Mole Removal • Scar Revision • General Dermatology • Fraxel® • Vbeam Perfecta®	• BOTOX® Cosmetic • Restylane® • Dysport® • Boletero® • Dermal Fillers • Facial Fine Lines/Wrinkles • Neck Wrinkles • Neck Tightening • Non Surgical Neck Lift • Skin Rejuvenation	• Skin Care Advice • Tattoo Removal • Acne Treatment • Acne Scar Treatment • Blotchy Skin • Facial Veins • Facial Redness • Facial Resurfacing • Brown Spots/Age Spots/Freckles

Please Describe Your Skincare Regimen:

AM:_____ PM:_____

_____ _____

_____ _____

_____ _____

_____ _____

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Office Policy on Insurance, Payments and Credit Card Authorization

As a courtesy service to you, our office employs a billing service and participates with several insurance carriers. Please familiarize yourself with your insurance practices and policies.

1. If your insurance carrier requires you to pay a portion of your healthcare visits (i.e. co-payment, deductible, co- insurance), we are legally required to collect these and no exceptions will be made. You are required to pay your co-payment at the time of your visit.
2. If your insurance carrier requires you to have a referral to be seen in our office, you must provide a referral or you will not be seen.
3. If your insurance requires you to meet an annual deductible before your healthcare is covered, you will be billed for the services rendered if you have not met your deductible. In addition you will be responsible for any charges accrued that your insurance company does not cover.
4. Returned checks: I understand that there is a charge of $35.00 for all returned checks.
5. You are responsible for all cosmetic charges at the time of service.
6. There is a NO REFUND policy on all cosmetic procedures._____ (Please Initial)
7. Please cancel your appointment at least 24 hours in advance or you will be a charge of $150.00._____ (Please Initial)

Please note that this will not compromise your ability to dispute a charge or your insurance company's determination of payment. Unless otherwise specified, we will contact you via email regarding your balance.

I have read the above carefully and acknowledge these terms. I hereby assume all responsibility for any outstanding balances and (if selected) understand that these charges will be applied to the credit card I have provided.

Sign _____ Date _____