ROBIN BORKOWSKY M.D. 133 EAST 58TH STREET, SUITE 508 NEW YORK, NY 10022

PATIENT'S NAME _____ DATE OF BIRTH _____

STREET ADDRESS _____ APT NUMBER _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE/HOME _____ **CELL _____ WORK _____

SOCIAL SECURITY# _____ EMAIL _____

SEX M____ F____ MARITAL STATUS MARRIED___ SINGLE___ DIVORCED ___WIDOWED ____

PATIENT'S EMPLOYER _____

OCCUPATION _____

PREFERRED PHARMACY AND LOCATION/PHONE NUMBER **ALL PRESCRIPTIONS WILL BE SENT ELECTRONICALLY TO A SPECIFIC PHARMACY FOR YOUR CONVENIENCE. _____

_____

EMERGENCY CONTACT _____

RELATIONSHIP _____ PHONE NUMBER _____

**REQUIRED FOR SURVEY THROUGH NYC GOVERNMENT:

RACE: ___ ASIAN ___ BLACK/AFRICAN AMERICAN ___ WHITE _____OTHER

ETHNICITY: ___HISPANIC ___ NON HISPANIC PREFERRED LANGUANGE: _____

INSURANCE

PRIMARY INSURANCE _____ MEMBER ID _____

GROUP #_____ **POLICY HOLDER _____ DOB_____

SECONDARY INSURANCE _____ MEMBER ID_____

AUTHORIZATION INFORMATION ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO **ROBIN BORKOWSKY M.D.** OF ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY INSURANCE, AND FOR ALL SERVICES RENDERED TO ME OR MY DEPENDENTS. I AUTHORIZE THE DOCTOR AND/OR ANY PROVIDER OR SUPPLIER OF SERVICES IN THIS OFFICE TO RELEASE INFORMATION REQUIRED TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. I AUTHORIZE A COPY OF THIS DOCUMENT TO BE USED IN PLACE OF THE ORIGINAL. I HAVE READ AND AGREED TO THE ABOVE.

SIGNATURE _____ DATE _____

PARENT/GUARDIAN (PRINT) _____ RELATIONSHIP TO PATIENT_____

Patient Name _____ **Date** _____

Medical Information

Please state the reason for your visit today _____

_____

Primary Care Physician's Name _____ Phone # _____

	Yes	No
Are you currently under medical treatment?	☐	☐
Please describe _____		
Have you ever had any serious illnesses or operations?	☐	☐
Please describe _____		
Are you taking any medications?	☐	☐

Please list: _____

_____

Please list any allergies _____

Have you had any reactions to the following?

Local Anesthetics _____ Penicillin _____ Latex _____

Sulfa Drugs _____ Aspirin _____ Iodine _____

Do you smoke? _____ Do you drink Alcohol? _____ Do you use Cocaine or other Drugs? _____

Please check any of the following conditions/illnesses you have:

Anemia _____ Arthritis _____ Bleeding Tendency _____ Blood Disease _____

Cancer _____ Chemical Dependency _____ Chicken Pox _____ Diabetes _____

Epilepsy _____ Heart Murmur _____ Heart Disease _____ Hepatitis/Type _____

Skin Cancer/Type _____ Herpes _____ High Blood Pressure _____

HIV/AIDS _____ Jaundice _____ Kidney Disease _____ Liver Disease _____ Migraine _____

Pacemaker _____ Skin Rash _____ Thyroid Problems _____ Venereal Disease _____

Women Only:

Do you have regular periods? Yes_____ no_____

Are you pregnant now? Yes_____ no_____

Please circle Birth Control: Birth Control Pills / IUD / Patch / Injection or other _____

133 East 58th Street, Suite 508 New York, NY 10022

Phone (212)644-4440 Fax (212)644-4447

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I, _____, have had the opportunity to read and receive a copy of 21st Century Dermatology's Notice of Privacy Practices.

_____ (initial) I authorize 21st Century Dermatology to leave information regarding my medical treatment on my voicemail or answering machine unless otherwise informed.

I authorize 21st Century Dermatology to discuss my Protected Health Information (PHI) (laboratory results, biopsy results) with the following family members listed below:

Name	**Relationship**
1._____	_____
2._____	_____

Signature of Patient_____ Today's Date _____

CANCELLATION POLICY

In an effort to maintain the highest quality of patient care, appointments at 21st Century Dermatology are not double-booked. In order to maintain this standard, all medical dermatology appointments cancelled with less than 24 business hours' notice will be charged a $100 cancellation fee. All cosmetic or surgical appointments cancelled with less than 48 business hours' notice will be charged a $200 cancellation fee.

There will be no exceptions.

Thank you in advance for your consideration.

I understand and agree to the above cancellation policy.

Signature: _____

Print Name: _____

Date: _____

Robin Borkowsky, MD, FAAD
21st Century Dermatology, PLLC
133 East 58th Street, Suite 508
New York, NY 10022

Dear Patient:

We value you as a patient and appreciate that you have entrusted us with your health care needs.

As you know, there are charges for each of the medical care services that we will provide for you. The copayments, deductibles and coinsurance amounts that we are obligated to collect from you are determined by the type and extent of health benefit coverage that your health benefit plan provides. Our office will be pleased to work with your health benefit plan in verifying your eligibility, benefits, and requirements for prior authorizations or referrals, but please be aware that your health plan does not guarantee the accuracy of its confirmation of coverage or benefits. Since you are ultimately responsible for payment of the medical services provided to you, it is our policy to obtain your credit card number and authorization to process a claim for payment should your health plan not honor the claim we submit for the services provided to you.

Your health benefits, including your responsibility for co-payments, deductibles and co-insurance are decisions made by your employer, not this office or your health plan.

In providing credit card information below, you authorize payment by credit card for services in the absence of coverage by your health benefit plan, including, but not limited to copayments, co-insurance, deductibles, and/or uncovered services in an amount not to exceed $1000. You will receive a receipt by email or regular mail after charges are processed. In the event that there are any problems with your credit card payment, by signing this document, you are agreeing to pay all collection costs and reasonable attorney's fees incurred in attempting to collect the account balance.

Finally, and most importantly, your credit card information will be kept in a secure and locked facility, accessible only to Dr. Borkowsky and the 21st Century Dermatology office manager.

Thank you for your understanding.

PATIENT NAME _____

NAME ON CREDIT CARD _____

CARD TYPE _____

CARD NUMBER _____

EXPIRATION DATE _____ SECURITY CODE _____

SIGNATURE _____ TODAY' S DATE _____