Dmitry Malkin, M.D.

333 East 34th Street 1K ♦ New York, NY 10016 ♦ Tel: (212) 255-8040 ♦ Fax: (646) 706-7415

Date_____

PATIENT INFORMATION FORM

Last Name_____ First Name_____

- Date of Birth___/___/_____ Sex M F

Marital Status M S D W Occupation_____

Address_____
_____
_____

Home Phone Number_____

Cell Phone Number_____

Email_____

Name of insurance **policy holder**_____

Other Insured's Name_____Other Insured's DOB_____ _

Primary Insurance_____ _____Insurance ID_____

Group number_____

Secondary Insurance_____Insurance iD_____

Group number_____

Employer_____

Name of Referring Physician_____

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Date_____

Last Name_____ First Name_____

To Whom It May Concern:

I, _____, authorize the payment of medical benefits to Dr. Dmitry Malkin by my insurance plan for services rendered.

I, _____, have received a copy of Dr. Dmitry Malkin's missed and cancelled visit policy and authorize my agreement with its terms

Signature_____ Date_____

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MISSED AND CANCELLED VISIT POLICY

What is your policy on rescheduling or canceling of appointments?

If you schedule an appointment the time is set aside just for you – please keep it. If you do not keep your appointment, you will be charged the full visit fee unless you cancel within 48 hours of the appointment time.

What is my liability if I missed my appointment and called in less than 48 hours in advance or not at all?

If you do not contact me to reschedule or cancel in a timely manner, you will be charged for the missed visit. The current fee for a missed visit is $125 for the 1st missed visit, with $225 (full visit fee) for each subsequent visit. Insurance companies will not pay any portion of a missed appointment. You will be asked to pay your missed appointment fee at your next visit; if credit card is on file then it will be charged for the amount.