METAMORPHOSIS
PLASTIC SURGERY
9171 Baltimore National Pike, Ste 205
Ellicott City, MD 21042
Phone: 410-465-3600
Email: info@DiscoverTheBeauty.com

Date: _____

Preferred Pronoun: _____ Patient's Name: _____
(Last) (First) (M.I.)

Responsible Party: (If patient is minor) _____

Street Address (Do Not Use P.O.Box)_____

City_____ State_____ Zip Code_____

Please circle one – OK to send mail or DO NOT send mail

Date of Birth _____ Sex: ___Male ___Female Race_____

Home Telephone (_____) _____ Work Telephone (_____) _____

Cell Phone (_____)_____ E-Mail Address _____

Is It OK to contact? Please circle one.
Home YES / NO WORK YES / NO CELL(TEXT) YES/ NO EMAIL YES / NO

Emergency Contact _____ Home Phone (_____)_____

Relationship to Patient _____ Work Phone (_____)_____

Insurance Policy _____ Policy Number _____

Policy Holder _____ Policy Holder DOB _____

PHOTOS: Dr. Markmann takes pre and postoperative photographs of all of his patients. These photos are required for your medical record. Photographs may also be taken during your surgical procedure as deemed appropriate by Dr. Markmann. Occasionally, we ask a patient for permission to use their photos for other purposes such as medical journals, magazines, the internet, or our patient photos on display in the office. Your photos will not be used without your knowledge and consent and your name will not be associated with the photos. You will be asked to sign a separate consent form to give us permission to use your photographs.

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for the use **in examination, testing, credentialing and/or certify purposes by The American Board of Plastic Surgery, Inc."** The Board requires that all identifiable characteristics, with the exception of a full face photograph or photograph of a uniquely identifiable characteristic, be blanked out for submission of materials for the Oral Examination of The American Board of Plastic Surgery to protect patient privacy.

FINANCING: Cosmetic surgery is not covered by insurance. Financing plans with low monthly payments are available. If interested in financing your surgery, brochures are available in the waiting room or ask our patient coordinator for details. We can also arrange for someone to call you to discuss financing options.

CONSULTATIONS: Cosmetic consultations are free; however, if you schedule a cosmetic consultation and during the examination it is determined that you have a medical condition or diagnosis, your insurance company will be billed for the office visit accordingly and you will be responsible for any co-payments or deductibles.

INSURANCE ASSIGNMENT I, the undersigned, have insurance with _____. I assign all medical benefits be paid directly to Metamorphosis Plastic Surgery, LLC and Daniel P. Markmann, M.D. for services rendered. I am financially responsible for all co-pays and deductibles or all fees for services rendered if the insurance company denies benefits. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

PAYMENT GUARANTEE I understand that I am financially responsible for all fees associated with my care as well as any accrued interest, attorney fees and collection costs if the account is turned over for collection.

I understand all of the above and all the information given by me is accurate to the best of my knowledge.

_____ _____
SIGNATURE OF PATIENT/PARENT/GUARDIAN DATE

_____ _____
WITNESS DATE