

The Rockoff Dermatology Center

1101 Beacon Street Brookline, MA 02446

28 Andover Street Andover, MA 01810

First Name: _____ M.I. _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security#: _____ Sex: Male Female

Cell Phone _____ Home Phone _____ E-Mail _____

Marital Status: S M D W Other: _____

Responsible Party (Parent/Guardian): _____ Relationship _____

Emergency Contact: _____ Relationship _____ Phone: _____

Race: Caucasian Asian Black Multi-Racial Native American Pacific Islands Other

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Unknown/Not Reported

Language Preference: English Spanish Other _____

Occupation: _____ Employer: _____ Work#: _____

Primary Care Physician: _____

Location: _____ Phone#: _____

Primary Insurance: _____ Policy#: _____ Co-pay _____

Policy Holder Name: _____ DOB: _____ SS#: _____

Patient Relation to Policy Holder: Self Spouse Child Other _____

Secondary Insurance: _____ Policy#: _____ Co-pay _____

Policy Holder Name: _____ DOB: _____ SS# _____

Patient Relation to Policy Holder: Self Spouse Child Other _____

Pharmacy Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

PLEASE SEE REVERSE SIDE FOR SIGNATURES

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*****COPAYMENTS ARE DUE AT THE TIME OF YOUR VISIT AND ARE COLLECTED AT CHECK-IN. WE DO NOT BILL FOR COPAYMENTS*****

*****IF YOUR INSURANCE REQUIRES A REFERRAL, IT MUST BE PRESENT AT THE TIME OF YOUR VISIT. PLEASE NOTIFY YOUR PRIMARY CARE DOCTOR OF THE DATE AND TIME OF YOUR APPOINTMENT SO THEY CAN PROCESS A REFERRAL FOR YOU*****

Thank you for your cooperation.

The Rockoff Dermatology Center

Medical information and payment authorization

I ACKNOWLEDGE RECEIPT OF THE ROCKOFF DERMATOLOGY CENTER FINANCIAL POLICY.

Signature: _____ Date: _____

I ACKNOWLEDGE RECEIPT OF THE ROCKOFF DERMATOLOGY CENTER HIPAA POLICY.

Signature: _____ Date: _____

I hereby authorize medical treatment from Alan S Rockoff, MD LLC Group. I consent to having photos, laboratory testing and pathology procedure that is medically necessary for my medical care

Signature: _____ Date: _____

I hereby authorize medical treatment from Alan S Rockoff, MD. I authorize any holder of medical information about me to release the Health Care Financial Administration and its agents, or other insurer, any information needed to determine these benefits payable for related services.

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn this service over to collection for non-payment after 90 days, then the patient is responsible for the bill, the interest, and collection. **I acknowledge that if I do not have a referral, I am responsible for payment.**

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PROVIDER FOR MY CHARGES. I HEREBY AUTHORIZE THE UNDERSIGNED PROVIDER TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO MY INSURANCE COMPANY IN WRITING OR BY FAX.

Signature (Patient or Parent of Minor): _____ Date _____