

**Rockoff Center**  
**For Dermatology, Laser & Plastic Surgery**  
**1101 Beacon Street 1E, Brookline, MA 02446**  
**Phone: 617-731-2390, Fax: 617-731-1283**  
**28 Andover Street, Andover, MA 01810**  
**Phone: 978-475-9230, Fax: 978-475-9231**  
**www.rockoffcenter.com**

**Rockoff Center Financial Policy**

**AGREEMENT TO PAYMENT POLICY** I acknowledge that I received a copy of financial policy and agree to the terms of payment due.

**AUTHORIZATION TO RELEASE INFORMATION** I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to Alan Rockoff, MD LLC, any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

**ASSIGNMENT OF BENEFITS** I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Alan Rockoff, MD LLC for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

**GUARANTEE OF PAYMENT** I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to Alan Rockoff, MD LCC are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

**WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES** I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practice of Alan Rockoff, MD LLC.

Print Name: \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party/ Relationship to Patient \_\_\_\_\_