1101 Beacon Street Brookline, Suite 1E
Brookline, MA 02446
(617) 731-2390

INTEGRATED DERMATOLOGY OF BROOKLINE

28 Andover Street Andover, Suite 1R
Andover, MA 01810
(978) 475-9230

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**: _____

<u>PLEASE SEE REVERSE SIDE FOR SIGNATURES</u>

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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.

Integrated Dermatology of Brookline

Medical information and payment authorization

I ACKNOWLEDGE RECEIPT OF THE INTEGRATED DERMATOLOGY CENTER FINANCIAL POLICY.

Signature:_____ Date: _____

I ACKNOWLEDGE RECEIPT OF THE INTEGRATED DERMATOLOGY CENTER HIPAA POLICY.

Signature:_____ Date: _____

I hereby authorize medical treatment from Integrated Dermatology of Brookline, LLC.
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 and Miaoyuan Wang, 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**_____