Registration

Patient Information

(First, Middle, Last Name) *(Date of Birth)*

(Address) *(City, State, Zip Code)*

(Home Telephone Number) *(Work Telephone Number)* *(Cell Telephone Number)*

(Nickname) *(Social Security Number)*

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed
Sex: ☐ Male ☐ Female

Employment Information

(Occupation) *(Employer)*

(Address) *(City, State, Zip)*

Spouse/Domestic Partner Information

(Name) *(Date of Birth)*

(Occupation)

(Employer) *(Employer Phone Number)*

Responsible Person (Primary Insured)

(Name) *(Date of Birth)* *(Relationship to Patient)*

(Address) *(City, State, Zip Code)*

(Phone Number) *(Social Security Number)* *(Occupation)*

(Employer) *(Employer Phone Number)*

Relative to Contact in Case of Emergency

(Name) *(Phone Number)* *(Relationship to Patient)*

(Address) *(City, State, Zip Code)*

How were you referred to our office?

	Please print the name of your source below
☐ By your Insurance ☐ By a Doctor ☐ By a Patient ☐ Other	______________________________

Which pharmacy do you use? ______________________________

Address: ______________________________

____

Phone: ______________________________

Consent to Treatment

I voluntarily consent to receive medical and health care services that may include diagnostic procedures examinations and treatment.

Financial Responsibility and Assignment of Benefits

I, ______________________________ understand that I am responsible for payment in full or any co-payment at the time services are rendered, as indicated by my insurance plan. I understand that any amounts not paid by my insurance are my responsibility. Should I not respond within a 90 day period for any unpaid balances, the amount will be turned over to a collection agency including all additional fees, legal or otherwise, as allowed by the state of Texas.

Billing policy available upon request.

Initial: _________

Medical Records Disclosure

I, ____ authorize the employees of Bradley Friedman MD PA (Friedman Family Practice) to disclose my (or my child's) medical records to the following individuals:

____

____

Initial: ___________

I do not consent to any disclosure of my medical records ☐
By checking this box we cannot discuss your records/results with your spouse/family etc.

Privacy Practices Acknowledgement

I have been provided an opportunity to review the notice of Privacy Practices (HIPAA): (available upon request)

Initial_____________

TREATMENT OF MINORS

Minors cannot be seen at Friedman Family Practice without the legal guardian's consent. Grandparents, Stepparents, and childcare practitioners must have written consent to treat from the legal guardian.

Controlled Substance Policy

It is the policy of this office that we do not routinely prescribe controlled substances such as narcotics (Vicodin, Percocet, Norco etc.) or benzodiazepines (valium, xanax, ativan, etc.). There are occasions where controlled substances are warranted however, they will only be prescribed in a very limited quantity and will not be refilled. These substances will also not be prescribed over the phone. If you have a condition that you feel requires either large quantities of such medications or long term use of such medications, we will be happy to refer you to the appropriate specialist for your condition. We cannot provide refunds for patients who are seen but feel they require larger dosages, quantities, or refills of controlled substances.
By signing below, I acknowledge that I have read and understood the controlled substance policy of Bradley Friedman M.D. P.A. and Friedman Family Practice.

Initial_____________

Missed Appointment Policy

I hereby acknowledge that it is the policy of Bradley Friedman M.D. P.A. that should I fail to show up for an appointment and do not notify the office at least three hours prior to the appointment, I will be billed a "missed appointment" fee of $25.

Initial_____________

OFFICE POLICIES

At Friedman Family Practice, we are dedicated to providing you with the best medical care available. In order to do that, we will need your assistance in providing us with necessary information. This information will be kept confidential and is protected by law. The information provided is used for the purpose of providing services to you and is shared with your insurance company for the purpose of reimbursement. If any type of lab work is done, this same information will be provided to the lab provider as well. We will not release your information to any other facility or person unless requested by you in writing.

We will file with your insurance if we are a participating provider under the plan for which you are enrolled. Any out of pocket expense, co-pay, deductible, or co-insurance is the responsibility of the patient, and is due at the time of service. If we are not a participating provider on the plan you are enrolled, payment will be due at the time of service. We accept various forms of payment. If a check will be used as payment, your driver's license must be provided.

** Unfortunately, we are not always aware of the particular details of each insurance plan. Therefore, please be sure you are aware of any exclusions and/or provisions with your plan. Any service not covered by the insurance will be the responsibility of the patient. Your insurance is a contract between you, your employer, and the insurance company. We file your claims as a courtesy but ultimately, medical charges are the responsibility of the patient.

If you have any questions or concerns with these policies, please feel free to contact our office.

Information on patient concerns for TSBME and TDI available upon request

By signing below (as the responsible party/legal guardian) I certify that I have read and understood all of the information above in pages one through three, and agree to the policies of Bradley Friedman M.D. P.A. (Friedman Family Practice). This form must be signed prior to services being rendered. It will become part of your permanent record with our office.

______________________	______________________	__________
Print	***Signature***	***Date***