PATIENT INFORMATION

AND FINANCIAL OBLIGATION

Ran Friedman, M.D., PLLC
(P) 972-905-1597
(F) 972-646-9085
1700 Alma Dr., Suite 480
Plano, TX 75075

Today's Date: _____

Patient Name: _____
(Last) (First) (Middle)

Preferred Pharmacy: _____ _____
(Pharmacy Name) (Pharmacy Address) (Pharmacy Phone/Fax Number)

Date of Birth: _____ Age: _____

Gender: _____

Marital Status: S ☐ M ☐ D ☐ W ☐ Other ☐

Sexual orientation: _____

Address: _____

_____
(City) (State) (Zip)

Phone:

_____ _____
(Cell) (Home)

_____
(Work)

E-mail: _____

Occupation: _____ Employer: _____

Student status: Full Time ☐ Part Time ☐ Other: ☐

If you are currently seeing another mental health professional, please provide their name and phone number:

_____

PATIENT CONSENT AND ACKNOWLEDGEMENT - Page 1 of 2

I have the legal right to consent to medical treatment by Ran Friedman, M.D., PLLC (also referred to here as the "practice," "Dr. Friedman," or "us") because I am either the patient or the parent/guardian with legal authority to consent on behalf of the patient.

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that the providers of Ran Friedman, M.D., PLLC believe are necessary. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, and other health care providers in this practice to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent.

I have also received a copy of Ran Friedman, M.D., PLLC's *Notice of Privacy Practices* in a format that is accessible to me and understand I have certain privacy rights with respect to the use and disclosure of my personal health information. I have been provided an opportunity to review the *Notice* and ask questions prior to granting consent and authorization to its terms, and do hereby consent to such terms and authorize such uses and disclosures.

I understand that I may revoke my authorization, in writing, at any time by notifying Ran Friedman, M.D., PLLC and the practice will no longer use or disclose that medical information in the future for the reasons covered by my original authorization. But, I also understand and accept that the practice will not be able to take back any uses or disclosures already made based on my prior authorization, and certain state or federal laws will still permit or require some uses or disclosures of my personal health information by the practice.

☐ I request the following restrictions on the use and/or disclosure of my personal health information:

_____

(*Initial all that apply*)

____ I authorize Dr. Friedman to electronically transmit prescriptions to the pharmacy of my choice and review pharmacy benefit information and medication dispense. This includes, but is not limited to, all available updates from the automated electronic medical record from all pharmacies where I fill in medications to help limiting medication interactions that can affect my treatment. This is not a substitution to in person reporting of new medications I take.

____ In the future event that I am either hospitalized in a medical or mental health unit or visit another medical or mental health provider, I **grant** permission to Dr. Friedman to discuss my diagnosis, medication management, and other details pertinent to my care. I also authorize the practice to electronically share my medical records with the other medical or mental health providers to allow and promote continuity of my care among providers.

____ As a service to patients, the practice provides courtesy appointment reminder calls/texts and possibly other important emails, correspondence, or calls that may use a prerecorded messaging system. The information may include protected health information, and while the practice will implement reasonable safeguards to protect your information, the practice cannot eliminate all potential risks of unauthorized access when transmitting these communications. By initialing on the left, you consent to receiving such communications at the methods of contact you have provided to us.

_____ / _____ / _____

Signature of Patient or Legal Representative / Date | Witness / Date

_____ / _____ | _____

Print Name / Relation to Patient | Print Name of Witness

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PATIENT CONSENT AND ACKNOWLEDGEMENT - Page 2 of 2

*I request that changes to the *Notice of Privacy Practices* be sent to me using the following contact method provided above:

- ☐ Email
- ☐ Address
- ☐ Other: _____

Payment in full is expected at the time of service. All alternative financial arrangements should be discussed with and approved by Dr. Friedman in writing. **Full fee applies for appointments broken or not canceled with at least 24-hours' notice**. Payment accepted is Credit Card only.

Prescriptions/ Refills

Please have the pharmacy call (or call yourself) my office at the number or fax listed above. Please call as early as possible to avoid running out of medications. In most cases, appointments within agreed upon frequency are necessary for prescriptions/ refills. Please make sure to allow time for scheduled appointments to take place in order to avoid delays in availability of prescriptions. **Refills outside of appointment times will incur a $25 fee.** However, in most cases, an appointment will be needed prior to approving refills. Clinical judgment will be applied.

Credit Card Authorization

I authorize Ran Friedman, MD, PLLC to charge my credit card for agreed upon mental health services: appointments, misses appointments without at least 24 hour notice, medication refills, services outside appointment times, like phone follow ups, forms requested to be filled, communications with other providers. Collecting information pertinent to my treatment from others will only take place with my written consent, other than as allowed by law and/or consented herein. I understand that my credit card information will be saved to file for future transactions on my account.

_____ _____

Signature of Patient or Legal Representative Date