

PATIENT REGISTRATION, CONSENT, AGREEMENT, AND AUTHORIZATION

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security# \_\_\_\_\_  
Telephone# \_\_\_\_\_ Work Telephone# \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Telephone# \_\_\_\_\_

I hereby consent to the use and disclosure of information in my medical records for treatment, payment, and health care operations. I understand that this consent is voluntary. I understand that information in my medical records may be used and disclosed to persons other than Lisa Beth Freedman, M.D. to carry out their responsibilities in connection with my medical/health care treatment, in payment for health care services rendered to me, and in activities related to health care operations.

I understand that medical treatment is necessary. I hereby consent to and authorize administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of Lisa Beth Freedman, M.D. I reserve the right to refuse any or all treatment.

I understand and agree that I am ultimately responsible to pay the charges for all services rendered to me. I understand that if, for whatever reason under my insurance guidelines, a service is determined to be non-covered, partially paid, or denied, I will be responsible for payment.

I request that payment of authorized insurance benefits be made on my behalf to Holistic Family Medicine for any services rendered to me by said group. Photocopy of this authorization shall be considered as effective and valid as the original.

If I am currently pregnant or planning to become pregnant over the next year, if I am currently using birth control or currently breast feeding, it is my responsibility to inform Lisa Beth Freedman, M.D. of these facts or intentions.

I have read the above statements, understand, and agree to them. I understand that they are a permanent part of my file. Should I wish to rescind my authorization, I must do so in writing.

\_\_\_\_\_  
Signature of Patient or Patient Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient/Patient Representative

\_\_\_\_\_  
Relationship to Patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR  
PROTECTED HEALTH INFORMATION

I acknowledge that I have received Lisa Beth Freedman, M.D.'s Notice of Privacy Practices for protected health information.

\_\_\_\_\_  
Signature of Patient or Patient Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient/Patient Representative

\_\_\_\_\_  
Relationship to Patient