LAWRIE FRIEDMAN M.D
670 North Coit Road Suite #2355
Richardson, Texas 75080

Patient Registration

Name of Patient_____ D.OB._____

Address_____ Apt #_____ City_____ Zip_____

Phone_____ Sex_____ SGL_____ Mar_____ Wid_____ Div_____

SS#_____ REFERRED BY_____

OCCUPATION_____ EMPLOYER_____

EMPLOYER'S ADDRESS_____Phone#_____

INSURANCE COMPANY_____

HOLDER OF INSURANCE_____ D.O.B._____

ADDRESS_____ Phone#_____

EMPLOYER_____

NAME OF RESPONSIBLE PARTY_____
(If Patient is a Minor)

RELATIONSHIP TO PATIENT_____

DAILY USE: TOBACCO_____ALCOHOL_____

PREFERRED METHOD OF PAYMENT: CASH____ CK_____ CREDIT CARD_____

Please note there will be a minimum charge of $25.00 for missed appointments.
You must cancel or reschedule at least 2 hours prior to your scheduled time.

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

_____ _____
Patient (Responsible Party) Signature Date

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Health services are made available to patients without discrimination on the basis of type of health benefit plan, sex, age, race color or religion.

Due to recent changes in privacy laws, we are unable to discuss any of your medical information (Lab/X-ray results, diagnosis, medication etc.) with anyone without your permission.

I give permission for the following people to have access to my medical information.

_____

_____

_____

I do not wish for anyone to have access to my medical information.

_____
Patient Name (Please Print)

_____
Patient Signature Date

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Credit Card Authorization

I,_____ hereby authorize Dr. Friedman's office
Patient Name
to charge my credit/debit card listed below for any outstanding balance owed by me not paid or covered by my insurance 30 days after an explanation of benefits (EOB) or notification is received by Dr. Friedman from the Insurance Company, unless payment in full is made by me during this 30 days period.

My Credit/Debit card information is as follows:

_____ _____ _____
Visa/MC/Discover Credit/Debit Card Number Expiration Date

Signed:_____ Date:_____
Patient Name

Signed:_____ Date:_____
Responsible Party if Patient is a minor