

**Friedman Plastics and ENT.**

**MEDICAL TREATMENT AGREEMENT**

Patients Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient or the patient's legal representative agrees to the following terms of Dr. Bryan D. Friedman D.O. encounters:

**1. MEDICAL TREATMENT:**

The patient consents to the treatment, services and procedures which may include but are not limited to laboratory procedures, X-ray examinations, medical and surgical treatments or procedures, anesthesia. The patient will be treated by his/her attending health care providers and be under his/her care and supervision.

**2. TEACHING PROGRAM:**

The clinic participates in training programs for providers and health care personnel. Some patient services may be provided by persons in training under the supervision and instruction of the providers or clinic employees.

**3. RELEASE OF INFORMATION:**

The patient acknowledges and agrees that medical and/or financial records (INCLUDING INFORMATION REGARDING ALCOHOL OR DRUG ABUSE, HIV RELATED OR OTHER COMMUNICABLE DISEASE RELATED INFORMATION) may be released to the following

- A. Healthcare providers or the agents who are providing or have provided health care to the patient; and individual or entity responsible for payment of the clinic or provider's charges; to healthcare providers or organizations accrediting the facility or conducting utilization review, quality assurance, or peer review; and to the clinic's and provider's legal representatives and professional liability carriers.
- B. Individuals and organizations engaged in medical education and research, that information may only be released for use in medical studies and research without patient identifying information.
- C. Individuals and entities as specified by federal and state law and/or in the Clinic's Notice of Privacy Practice.
- D. Patients records of services provided at this facility may be exchanged among other facilities where necessary to provide appropriate patient care. This release shall continue for as long as the medical and/or financial records are needed for any of the above-stated purposes.
- E. This is an assignment of benefits of my rights and benefits under my insurance. I authorize the release of any medical information necessary to process claims and direct payment of benefits from my insurance company.

**4. CONTRABAND:**

Drugs, alcohol, weapons, and other articles specified as contraband by the Clinic may not be brought on the premises. And illegal substance will be confiscated and turned over to law enforcement authorities.

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**5. PHOTOGRAPHS/TAPED THERAPY SESSIONS:**

I understand and agree that a photograph may be taken of me for identification purposes or for other treatment purposes. I further agree that therapy sessions may be taped (audio/video) and that all photographs and tapes will remain the property of the clinic.

**6. FINANCIAL OBLIGATIONS:**

I acknowledge that it is my responsibility as the patient to follow up with Insurance in regards to in-network providers, as well as prior authorizations, and referrals. Failure to do so, could result in out of pocket costs.

**7. COMMUNICATION:**

"By providing my telephone number and e-mail address to Friedman Plastics and ENT, I agree and acknowledge that Dr. Friedman and staff may use my telephone number and/or e-mail for various purposes, including, without limitation, to communicate post-operative care instructions and appointment reminders, and for other marketing purposes. I acknowledge that this consent may be removed at my request but until such, I may receive text messages and e-mails from Friedman Plastics and ENT."

- \_\_\_ Okay to call my home and leave a message.
- \_\_\_ Call my home phone but DO NOT leave a message.
- \_\_\_ DO NOT call my home phone, CALL ONLY this number, okay to leave a message. (    ) \_\_\_\_\_ - \_\_\_\_\_
- \_\_\_ DO NOT speak to family members.
- \_\_\_ Okay to send me my health information by encrypted email. Email: \_\_\_\_\_

I authorize the following individuals to inquire and receive verbal information regarding my care and finances.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. I have received the Notice of Privacy Practices. I am the patient, the parent of a minor child, or the legal representative of the patient and am authorized to act on the patient's behalf to sign the agreement.

\_\_\_\_\_  
Parent/Authorized representative

\_\_\_\_\_  
Date