FRIEDMAN PLASTICS AND ENT
MEDICAL TREATMENT AGREEMENT

Patient Name: _____Date of Birth: _____

The patient or patient's legal representative agree(s) to the following terms of Bryan D. Friedman, DO encounters:

1. **MEDICAL TREATMENT**
   The patient consents to the treatment, services, and procedures which may include, but are not limited to laboratory procedures, medical and surgical treatments or procedures, and anesthesia. The patient will be treated by his/her attending healthcare providers and be under his/her care and supervision.
2. **TEACHING PROGRAM**
   The clinic participates in training programs for providers and healthcare 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 healthcare to the patient; an 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 the clinic's and provider's legal representatives and professional liability carriers.
   B. Individuals and organizations engaged in medical education and research. Information may only be released for use in medical studies and research without patient identification information.
   C. Individuals and entities as specified by federal and state law and/or in the clinic's Notice of Privacy Practices.
   D. Patient 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. Any illegal substance will be confiscated and turned over to law enforcement authorities.
5. **PHOTOGRAPHS/TAPED THERAPY SESSIONS**
   I understand and agree that a photograph of me may be taken for identification purposes or for other treatment purposes. I further agree that therapy sessions may be taped (audio/video) and that all photographs and/or tapes will remain the property of the clinic.
6. **FINANCIAL OBLIGATIONS**
   I understand that it is my responsibility as the patient to follow up with insurance in regard to in-network providers, as well as prior authorizations and referrals. Failure to do so could result in out-of-pocket costs.

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7. COMMUNICATION

By providing my telephone and email address to Friedman Plastics and ENT, I agree and acknowledge that Dr. Friedman and staff may use my telephone number and/or email address 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 consent is revoked, I may receive text messages and emails from Friedman Plastics and ENT.

_____ Okay to call my home/cell telephone and leave a message
_____ Call my home/cell telephone but DO NOT leave a message
_____ DO NOT call my home/cell telephone
_____ Okay to send me my health information by email at _____

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

1. _____
2. _____
3. _____

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 and sign the agreement.

I consent to the release of my medical records along with any documentation regarding my care.

_____ _____
Patient/Authorized Representative Date