-PATIENT REGISTRATION, CONSENT, AGREEMENT, AND AUTHORIZATION:

Patient Name: _____ Date Of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone #: _____ Work Phone #: _____

Home Phone #: _____ Email Address: _____

Emergency Contact: _____ Phone #: _____

I hereby consent to the use and disclosure of information in my medical records for treatment, payment, and healthcare 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.

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 information.

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/Print Name of Patient or Patient Representative Date