BLAKE FRIEDEN MD, PA Registration Form

Name: _____ Today's Date: _____
First Middle Last

Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: ( ) _____ Birthdate: _____ Age: _____
Cell Phone: ( ) _____ Social Security Number _____-____-_____
EMAIL: _____

Race/Ethnicity: White / Hispanic / Black-African American / Native American / Asian
Middle Eastern / Ashkenazi / Sephardic / Pacific Islands

Primary Language spoken _____

Occupation: _____ SSN: _____
Employer: _____
Work Phone: ( ) _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: ( ) _____ Birthdate: _____ Age:_____
Occupation: _____ SSN:_____
Employer: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Work Phone: ( ) _____

SIGNIFICANT OTHER (circle 1): Spouse/Boyfriend/Fiancé/Significant Other /Father of Baby

Name _____ Birthdate: _____ Age: _____
Phone (home)_____ Phone (cell) _____
Occupation: _____
Employer: _____

Other Contact Information

In case of emergency, contact: _____ Relationship: _____
Home Phone: ( ) _____ Cell Phone: ( ) _____

EMERGENCY CONTACT PHONE NUMBER MUST BE DIFFERENT FROM YOUR OWN…Thank You.

How did you learn about this practice? _____

PHARMACY: ( )Walgreen's ( )Wal-Mart ( ) Target
( ) Tom Thumb ( ) Other ( ) CVS

Cross Streets: _____ City: _____
Telephone: ( )_____

I hereby give permission to Blake Frieden MD, PA to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and /or close personal friend(s) :
Name_____ Relationship _____ Phone Number_____
Name_____ Relationship _____ Phone Number_____
Name_____ Relationship _____ Phone Number_____

_____ I do not wish to give permission for any family members/relatives/friends to have access to any information regarding my medical condition (s)

Signature of Patient of Legal Representative: _____

Date : _____

Assignments of Benefits

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **Blake Frieden, M.D., P.A.** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **Blake Frieden, M.D., P.A.** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from **Blake Frieden, M.D., P.A.** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

Consent for Treatment

I have requested medical, obstetric, and/or surgical services from Blake Frieden MD, PA, and signing this form, I acknowledge that I voluntarily consent to treatment by Blake Frieden MD and any of his associates, including nurses, physician assistants, nurse-practitioners, medical assistants, call-partner physicians or any other designated personnel who are under his control. I voluntarily consent to and authorize Blake Frieden MD, PA to perform such diagnostic tests, physical exams, ultrasounds, biopsies, administration of medications, and other tests as may be needed, necessary or desirable in the professional judgment of the attending physician, Physician Assistants, Nurse practitioners, Ultrasonographers or other licensed personnel. Consent to treatment referred to here will include, but not be limited to, routine blood and urine screening and testing; testing for HIV or other sexually transmitted infections; urine or blood testing for alcohol, tobacco, or prescription or illicit drugs; and basic office procedures including biopsy, fetal monitoring, ultrasound, injection of anesthetics and medications, public display of photography provided by patients. I am aware that the practice of medicine and surgery and obstetrics and gynecology is NOT an exact science and I acknowledge that no guarantees or assurances have been made to me as to the result of any treatment, test, diagnosis, pregnancy, surgery or outcome.

I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED OR EXPLAINED IN A SATISFACTORY MANNER. BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ OR HAD IT READ OR EXPLAINED TO ME AND I UNDERSTAND THIS FORM AND I VOLUNTARILY CONSENT TO ALLOW Blake Frieden MD, PA, OR ANY PHYSICIANS DESIGNATED OR SELECTED BY Dr Frieden AND ALL MEDICAL PERSONNEL UNDER THE DIRECT SUPERVISION AND CONTROL OF SUCH PHYSICIANS AND ALL OTHER PERSONNEL WHICH MAY OTHERWISE BE INVOLVED IN PERFORMING SUCH PROCEDURES, TO PERFORM THE PROCEDURES AND SERVICES DESCRIBED ABOVE OR OTHERWISE REFERRED TO HEREIN.

_____

Print Name

_____ _____

Signature Date

Consent to Treat a Minor

(if applicable)

I hereby give my parental consent to treat _____, a minor in the State of Texas.

This consent extends to Blake Frieden MD, PA, and includes but is not limited to

- Routine gynecologic evaluation and treatment
- Birth control (pills, patches, rings, implants, injections, and devices)
- STD testing including HIV testing
- Pregnancy testing
- Blood testing
- Pelvic examination
- Pain management

_____

Signature of Parent or legal guardian

_____

Relationship

_____

Date

Cancellation Policy

Dr. Frieden's goal is to provide quality visits that are not rushed and do not have a time limit. He also makes every attempt to keep the office running on schedule. Sometimes, emergency office visits and delivery of babies will cause him to run late. He will make every attempt to have you contacted in advance when the office is running behind.

Same day urgent visits are almost always accommodated. For routine visits, Dr. Frieden will offer reasonably prompt scheduling.

To help Dr. Frieden provide prompt scheduling and an efficient office schedule, a 24 hour notice of cancellation is required by our office. Failure to cancel or reschedule without at least 24 hours notice will result in a $50 late cancellation fee. This will include "no-shows" to appointments. Repeatedly not keeping appointments may result in dismissal from this practice.

Thank you for helping the office run on-time, and allowing Dr. Frieden to spend as much time as you need during your appointments.

I have read and understand the above policy

_____ _____

Patient Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Acknowledgments

No VBACs (Vaginal Birth After C-section)

___ (initials)

I understand that Dr. Frieden does not perform VBACs (vaginal birth after c-section), and that if I have had a c-section, Dr Frieden will only perform a repeat c-section on me. If I prefer to attempt a vaginal delivery, I will ask Dr Frieden to help transfer my care to a different physician. If I change my mind toward the end of pregnancy, it may be difficult to find a physician to agree to take over my care, but this will be my responsibility. I agree to give Dr. Frieden as much notice as possible if this situation arises.

Obstetric Ultrasounds (Sonograms)

___ (initials)

My doctor has recommended an ultrasound. I understand that this ultrasound is to be performed to check fetal growth, fetal number, dating of my pregnancy, as well as other information that will be helpful in following my pregnancy. I understand that a routine ultrasound is not performed to detect congenital defects, although occasionally certain large defects may be identified. I also understand that ultrasounds are only 75% accurate in determining the sex of my baby and are not specifically performed for this purpose.

Call Partner and Delivery of Baby

___ (initials)

I further understand that Dr. Frieden is in a "call group" of other Obstetrician-Gynecologists, and that on rare occasion, they are involved with delivering his patients. He has informed me that they cover for him on weekends and holidays, and occasional other instances, and that although he is usually available for his own deliveries (90-95% of the time) it is *possible* that one of the call partners will be providing my care including delivery or C-section.

Acknowledgments

If you require medically necessary surgery or lab work, or if you require infertility assistance that is beyond the scope of my practice, you may be referred to any of several facilities that provide state of the art medical care, technology, and customer service. The Ambulatory Surgery Center, here at Medical City Dallas, Arbor Diagnostic Laboratory, and Aspire Fertility Clinic may be among facilities I enlist in providing you with excellent health care.

I feel personally compelled to ensure that all my patients are aware of financial interests I maintain in these referring facilities, and I welcome your feedback relating to your experience with them.

Appointment Reminder System

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize Blake Frieden MD, PA to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I consent to the receiving of multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, if I am unavailable at the number I provided. There will be no medical information sent by text, or by email unless specifically requested.

_____

Print Name

_____ _____

Patient Signature Date