LAKEVIEW TMS CENTER

DIRECTIVE FOR HANDLING OF APPOINTMENTS AND BILLING INFORMATION

This form authorizes us to contact or leave messages for you and all listed for appointment and billing information. For adult patients, if someone other than yourself will be paying for your visits you must list that individual below to authorize us to collect appropriate payment.

Name of Patient _____ Name of Contact _____

I, undersigned Patient, Parent, Guardian, or Personal Representative authorize the office of Lakeview TMS Center to contact me in the following ways:

	Number/E-Mail	May leave a message (Y/N)	Preferred
Home			
Work			
Cell			
Fax			
Email			

Other persons we may contact: (If anyone other than the patient or legal guardian is providing payment, please list their contact information below to discuss and handle any potential payment issues.)

Name	Relationship	Number/Email	Message (Y/N)

I further authorize the office of Cini Abraham MD., P.A. to contact the Emergency Contact(s) listed on the registration page.

Please list any special instructions for contacting you or sharing this information:

_____

_____

Signature: Patient: Date:

_____

OR Parent/Guardian/Legal Responsible Person:

_____

If the patient is either under age or has a guardian appointed by court, this request must be signed by the patient's legal guardian. If the request is signed by a personal representative of the patient, a legal document stating such representative's authority to act for the patient must be provided.

Lakeview TMS Center 2249 Ridge Road, Rockwall, TX 75087 469-402-7867
or fax 469-402-7868