Rockwall Psychiatry
2249 Ridge Rd Rockwall, TX 75087
469-402-3600 * Fax 469-402-3606
www.rockwallpsychiatry.com

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 Cini Abraham M.D., P.A. to contact me and **leave a message including clinical** information in the following ways:

Number/Email

Home ____________________________________

Work ____________________________________

Cell ____________________________________

Fax ____________________________________

Email ____________________________________

*There is always a risk in sharing information electronically. Please know that information shared via email, fax, or text could be saved to the internet and has the potential to be altered.

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 M.D., P.A. to contact the Emergency Contact(s) listed on the registration page.

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.