

Joan M. Franklin Ph. D.
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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 Joan M. Franklin, Ph.D. to contact me in the following ways:

	Number/Email	May leave a message(Y/N)	Preferred
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 Joan M. Franklin Ph.D. 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.