DR. JEFFREY D. GABER
& ASSOCIATES, PA

PATIENT'S NAME _____ **DOB** _____

(Please Print)

CONSIGNMENT & ASSIGNMENT

PLEASE READ BEFORE SIGNING

MEDICARE

I authorize any holder of medical or other information about me to release to the Social Security Administration & Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (Title XVIII). I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below. I understand that I am responsible for any health insurance deductibles, co-insurance (co-pay) and non-covered charges.

BLUE SHIELD OF MARYLAND

I understand the charge of a non-participating physician may exceed the Blue Shield of Maryland, Inc. or Carefirst, Inc. payment and, if greater, I will be responsible for that amount. For charges of a participating provider, I understand that I am responsible for any health insurance deductibles, co-insurance (co-pay) and non-covered charges.

COLLECTION FEES

The undersigned expressly agrees that if, upon default, this matter is referred for collection, the undersigned agrees to pay an attorney's fee of twenty-five percent (25%) of the outstanding balance at the time of referral, which percentage and the amount resulting there from are considered reasonable by the undersigned, and any and all court costs incurred therewith, as well as private process server fees.

INSURANCE ASSIGNMENT

I hereby assign, transfer and set over to Dr. Jeffrey D. Gaber & Associates, P.A. all of my rights, title, and interest to my reimbursement benefits under my insurance policy with Insurance Company.

Insurance Co. or Attorney _____

MANAGED CARE

I understand that, without an authorization/referral from my insurance carrier, if so required, that I will be financially responsible for 100% of charges I and/or the patient incur.

PAYMENT

I will pay to Dr. Jeffrey D. Gaber and Associates Any balance due for services rendered. I Understand that if full payment is not made on my behalf by my (insurer, Legal representation, or workers compensation insurance) I will be responsible for any outstanding balance.

SIGNATURE OF PATIENT, RESPONSIBLE PARTY, PARENT OR LEGAL GUARDIAN

Below I affix my seal.

Signature _____ Date _____

I authorize a copy of this authorization to be used in place of the original.

GUARANTEE

As an inducement for the providing of services to the patient, the undersigned absolutely and unconditionally guarantees to Dr. Jeffrey D. Gaber & Associates, P.A., and its successors and assigns, the full and complete payment due.

SIGNATURE OF SPOUSE

Below I affix my seal.

Signature _____ Date _____