DR. JEFFREY D. GABER
& ASSOCIATES, PA

PATIENT INFORMATION SHEET

Please Print - Complete All Information

SOCIAL SECURITY# _____ TODAY'S DATE _____

LAST NAME _____ FIRST NAME _____ MI _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

DATE OF BIRTH _____ ❑ MARRIED ❑ SINGLE ❑ WIDOWED ❑ DIVORCED SEX: ❑ MALE ❑ FEMALE

DRIVER'S LICENSE# _____

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP TO PATIENT _____

REFERRED BY: ❑ ATTORNEY _____ ❑ OTHER

ADJUSTER NAME _____ PHONE _____

CLAIM # _____

EMPLOYER _____ ADDRESS _____ PHONE _____

EMPLOYMENT STATUS: ❑ FULL-TIME ❑ PART-TIME ❑ UNEMPLOYED ❑ STUDENT ❑ HOUSEWIFE/HUSBAND

WORKER'S COMPENSATION / PERSONAL INJURY

❑ AUTO ACCIDENT ❑ WORK COMP ACCIDENT ❑ OTHER

DATE OF ACCIDENT _____ WHAT AREAS WERE INJURED? _____

DESCRIPTION OF ACCIDENT _____

WERE YOU TAKEN TO THE HOSPITAL OR RECEIVE TREATMENT FOR THIS INJURY? IF SO, WHERE?

_____

WERE X-RAYS TAKEN? _____ MEDICATION PRESCRIBED? _____

CURRENT COMPLAINTS _____

ANY PRIOR INJURIES? IF YES, GIVE DATES AND DESCRIPTIONS _____

_____

BRIEF MEDICAL HISTORY

❑ HIGH BLOOD PRESSURE
❑ HEART DISEASE
LAST MENSTRUAL PERIOD
_____

❑ DIABETES
❑ ASTHMA
❑ TOBACCO USE
❑ ULCERS

❑ CANCER
❑ KIDNEY DISEASE
❑ ARTHRITIS
❑ SURGERY

❑ OTHER _____
_____

CURRENT MEDICATIONS _____

MEDICATION ALLERGIES _____

PRIMARY CARE PHYSICIAN _____

HEIGHT FT. _____ INCHES _____ WEIGHT _____ LBS

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 _____

DR. JEFFREY D. GABER
& ASSOCIATES, PA

BY SIGNING BELOW I ACKNOWLEDGE RECEIVING
DR. JEFFREY D. GABER & ASSOCIATES, PA'S "NOTICE OF PRIVACY PRACTICES."

Patient's Name _____

Date of Birth _____

Signature of Patient or Legal Guardian _____

Date _____

DR. JEFFREY D. GABER
& ASSOCIATES, PA

SELF-PAY WAIVER

I, _____ , fully understand and agree that I will be responsible for any and all services that I receive by and through Dr. Jeffrey D. Gaber & Associates, P.A., related to an accident or injury that I sustained on or about _____ . Dr. Jeffrey D. Gaber & Associates, P.A., will not bill, nor accept payment from my private health insurance.

I also agree that if my injury claim is denied or in the event that any liability insurance payment or settlement that I receive is not adequate to cover these charges, that I will be held responsible for payment of these services in full.

STATUTE OF LIMITATIONS WAIVER

I, _____ ,do hereby waive my right to the three-year statute of limitations for the collection of any medical services provided by Dr. Jeffrey D. Gaber & Associates. P.A.

Agreed Signature _____

Date _____

Witness _____

DR. JEFFREY D. GABER
& ASSOCIATES, PA

AGREEMENT AND AUTHORIZATION FOR DIRECT PAYMENT

I hereby authorize, assign, and direct my attorney to pay Dr. Jeffrey D. Gaber & Associates, P.A. such sums as may be owing to them for professional services rendered in the treatment of injuries sustained by me/ my wife/my child as the case may be. If applicable, I authorize, assign, and direct my attorney to pay such sums from the proceeds of any settlement, judgment or insurance policy, as may be necessary to adequately protect Dr. Jeffrey D. Gaber & Associates, P.A. Such payments will include all professional services rendered, and those rendered up to the time of settlement, including, but not limited to, the appearance as an expert witness inn lawful court, and such time as may be necessary to properly prepare and travel for such testimony. I further understand that my attorney(s) may request your appearance in lawful court and acknowledge that such appearance is solely for my benefit and accept full responsibility for your fees associated with such appearance, such fees to be fixed at a rate of $500 per hour.

I authorize, assign, and direct any insurance carrier to pay directly to Dr. Jeffrey D. Gaber & Associates, P.A. such sums as may be owing to said for professional services as outlined above. I direct my attorney(s) to submit a copy of this AGREEMENT AND AUTHORIZATION FOR DIRECT PAYMENT to any and all insurance carriers which may be responsible for the payment of such sums, including an insurance carrier providing personal injury protection coverage to which I may be entitled.

I understand that any balance due on my account will be deducted from settlement proceeds even though Dr. Jeffrey D. Gaber & Associates, P.A. may now be, or at a future date may become, my primary caregiver in any health maintenance organization or managed care network.

I understand that I am directly and fully responsible to Dr. Jeffrey D. Gaber & Associates, P.A. for all bills submitted by Dr. Jeffrey D. Gaber & Associates, P.A., including attorney(s) fees of 25% of the balance due plus all costs resulting from efforts to collect any balance due, and that this agreement is made solely for their additional protection and in consideration of them awaiting payment. I further understand that my liability to pay Dr. Jeffrey D. Gaber & Associates. P.A. is not contingent on any settlement. judgment or verdict from which I may eventually recover such fee.

In the event I directly receive any proceeds of any insurance policy, including but not limited to proceeds from any claim under my personal injury protection coverage, I agree to immediately make payment to Dr. Jeffrey D. Gaber & Associates, P.A. upon receipt of such monies.

I hereby waive the defense of the three-year statue of limitations.

A PHOTOCOPY OF THIS AGREEMENT SHALL BE BINDING AS THE ORIGINAL.

Date _____ Signature _____

Address _____ Witness _____

City _____ State _____ Zip _____ Date _____

Day Phone Number _____ Evening Phone Number _____

Attorney's Name _____ Phone _____

DR. JEFFREY D. GABER
& ASSOCIATES, PA

PATIENT AUTHORIZATION FOR PRACTICE TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Dr. Jeffrey D. Gaber & Associates, PA to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below. This authorization is needed for a purpose other than treatment, payment or health care operations. I have read this authorization and understand what information will be used or disclosed.

I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization in writing except to the extent that Dr. Jeffrey D. Gaber & Associates, PA has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at Dr. Jeffrey D. Gaber & Associates, PA. I further understand there is a charge for copying and handling my request. I understand that all fees will be in compliance with applicable Maryland State guidelines.

This authorization permits Dr. Jeffrey D. Gaber & Associates, PA to use or disclose to _____ the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, patient's name, age, race, condition or other medical or demographic information)

- Consultation Reports
- Discharge Summary
- Drug or Alcohol Treatment Records
- Emergency Room Records
- Medical Records/Notes
- Mental Health Records
- Operative Report
- Outpatient Records
- Outpatient Surgery
- Pathology Report
- X-Ray Report
- Other _____

I understand that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

This authorization expires on (upon) _____

Signature of Patient or Legal Guardian _____

Relationship to Patient _____

Patient's Name _____

Print Name of Patient or Legal Guardian _____

Date of Birth _____