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 ______________________

EMPLOYER ______________________ ADDRESS ______________________ PHONE ______________

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

REFERRED BY: ❑ DOCTOR ______________ ❑ FRIEND ❑ OTHER PATIENT

❑ INSURANCE CO. ______________________ OTHER ______________________

PRIMARY INSURANCE COVERAGE

RESPONSIBLE PARTY FOR BALANCE: ❑ SELF ❑ PARENT ❑ OTHER (explain) ______________________

PRIMARY INSURANCE ______________________

INSURANCE POLICY ID# ______________________ GROUP# ______________ EFFECTIVE DATE OF INSURANCE ________

SUBSCRIBER (PERSON WHO OWNS THE INSURANCE) ______________________

PATIENT'S RELATIONSHIP TO SUBSCRIBER ______________ SUBSCRIBER'S SOCIAL SECURITY# ______________

SUBSCRIBER'S ADDRESS ______________________ CITY ______________ STATE _____ ZIP ________

SUBSCRIBER'S DATE OF BIRTH ______________ SEX: ❑ MALE ❑ FEMALE

SECONDARY INSURANCE COVERAGE

❑ SAME AS PRIMARY

SECONDARY INSURANCE ______________________

INSURANCE POLICY ID# ______________________ GROUP# ______________ EFFECTIVE DATE OF INSURANCE ________

SUBSCRIBER (PERSON WHO OWNS THE INSURANCE) ______________________

PATIENT'S RELATIONSHIP TO SUBSCRIBER ______________ SUBSCRIBER'S SOCIAL SECURITY# ______________

SUBSCRIBER'S ADDRESS ______________________ CITY ______________ STATE _____ ZIP ________

SUBSCRIBER'S DATE OF BIRTH ______________ SEX: ❑ MALE ❑ FEMALE

SUBSCRIBER'S EMPLOYER ADDRESS ______________________ CITY ______________ STATE ________ ZIP ________

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 __________

**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 FOR PRIVATE PATIENTS

I, ____________________________________, understand and agree that I will be held responsible for any and all services that I receive by and through Dr. Jeffrey D. Gaber & Associates, P.A., that are not covered by my health maintenance/insurance plan.

I further understand that I will be held responsible for payment of these services in full, in the event that my health insurance does not cover these charges.

Agreed ____

Date ____

Witness ____

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 _____________________________________

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 <u>I am directly and fully responsible</u> 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 <u>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.</u>

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

DR. JEFFREY D. GABER AND ASSOCIATES, P.A.
PATIENT – PROVIDER E-MAIL COMMUNICATION FORM

Keep in the Patient's Medical Record

I allow Dr. Jeffrey D. Gaber and Associates, PA to use electronic mail (e-mail) to communicate clinical information to me pertaining to health care services that I have received. I acknowledge and understand that e-mail communication may contain my personal and private medical information including, but not limited to, my name, address, date of birth, types and dates of health care services received, medication, insurance coverage information, and/or test results.

I understand that, although Dr. Jeffrey D. Gaber and Associates, PA may attempt to protect the privacy of the contents of email sent to me and will take reasonable measures to protect my privacy, the e-mail messages sent to me are not encrypted and travel over the Internet. As a result, there is a risk that the e-mail will be intercepted and read by unauthorized third parties. In allowing Dr. Jeffrey D. Gaber and Associates, PA to send me e-mail, I assume this risk.

I also acknowledge and understand the following as it relates to this e-mail communication:

1. E-mail is not appropriate for conveying information relating to urgent or emergency medical matters. If I am experiencing an urgent or emergency situation, I understand that I should dial 911 immediately.
2. If an e-mail has not been answered, I should call to make sure that it has been received and I may make an appointment to see/speak with the health care provider to discuss the e-mail message.
3. I will not use e-mail for discussion of sensitive or highly confidential issues; for example, mental health or reproductive issues, etc. If there are specific types of information that I do not want included in emails (e.g., lab results), it is my responsibility to notify Dr. Jeffrey D. Gaber & Associates, PA.
4. Employees of Dr. Jeffrey D. Gaber & Associates, PA other than the Provider may have access to my e-mail address and e-mail content such as triage nurses, consulting physicians, and other health care providers that are permitted access to my medical records.
5. I, and not the Provider or Dr. Jeffrey D. Gaber & Associates, PA, am responsible for the security of e-mail communications sent from or stored on my computer.
6. My decision to allow Dr. Jeffrey D. Gaber and Associates, PA to communicate with me by e-mail is voluntary, and that treatment is not conditioned upon my election to do so.
7. Dr. Jeffrey D. Gaber and Associates, PA or I may stop e-mail communication at any time for any reason.
8. I agree to notify Dr. Jeffrey D. Gaber and Associates, PA when my e-mail address changes.
9. I will not hold Dr. Jeffrey D. Gaber & Associates, PA responsible for damages resulting from their use of e-mail or the failure of any Dr. Jeffrey D. Gaber & Associates, PA information systems used to facilitate the e-mail communication.
10. I understand that all emails related to my care received or generated by Dr. Jeffrey D. Gaber & Associates, PA will be maintained in my medical record.

The Provider may send medical information to my e-mail address, which is:

Email Address ____

The Provider may communicate via email to the designated individual listed below.

Name ____

Relationship to Patient ____________________ Email Address ____________________

Patient Name (Print) ____

Patient /Representative Signature ______________________________ Date ______________