Dr. Jeffrey D. Gaber & Associates, PA

PATIENT INFORMATION SHEET – Please Print – Complete All Information

SOCIAL SECURITY # _____ - _____ - _____ TODAY'S DATE: _____

LAST NAME: _____ SUFFIX: _____ FIRST NAME: _____ MI: _____

ADDRRESS: _____ CITY: _____ STATE: _____ ZIP:_____

HOME PHONE: (_____) _____ WORK PHONE: (_____) _____ EXT: _____

DATE OF BIRTH: _____ MARRIED: _____ SINGLE: _____ WIDOWED: ____ DIVORCED: ____ SEX: ____MALE _____ FEMALE

DRIVER'S LICENSE #: _____ EMERGENCY CONTACT: _____ PHONE: (____) _____

CELL PHONE/PAGER: (___) _____ FOR MINORS: MOM'S WORK PHONE: (_____) _____ DAD'S WORK PHONE: (____) _____

PHARMACY: _____ ADDRESS: _____ PHONE: (_____) _____

EMPLOYER: _____ ADDRESS: _____

PHONE: (___) _____ EMPLOYMENT STATUS: __FULL-TIME __PART-TIME ___UNEMPLOYED ___STUDENT ___HOUSEWIFE/HUSBAND

REFERRED BY: DOCTOR _____ ADDRESS _____

FRIEND _____ OTHER PATIENT _____ INSURANCE CO. _____ OTHER _____

PRIMARY INSURANCE COVERAGE

RESPONSIBLE PARTY FOR BALANCE: _____ SELF _____ PARENT _____ OTHER (explain) _____

PRIMARY INSURANCE: _____ CLAIMS ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ PHONE: (_____) _____

CO-PAY: $_____ SUBSCRIBER (PERSON WHO OWNS THE INSURANCE): _____

PATIENT'S RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER'S SOCIAL SECURITY #:_____ - _____ - _____

SUBSCRIBER'S ADDRESS: _____ CITY_____ STATE_____ ZIP CODE_____

HOME PHONE: (____)_____ WORK PHNE: (_____) _____ BIRTH DATE: _____ SEX: _____MALE _____ FEMALE

SUBSCRIBER'S EMPLOYER: _____ ADDRESS: _____ CITY: _____ STATE: ____ ZIP CODE:_____

INSURANCE POLICY ID #: _____ GROUP #: _____ EFFECTIVE DATE OF INSURANCE: _____ _____

SECONDARY INSURANCE COVERAGE

PRIMARY INSURANCE: _____ CLAIMS ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ PHONE: (_____) _____

CO-PAY: $_____ SUBSCRIBER (PERSON WHO OWNS THE INSURANCE): _____

PATIENT'S RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER'S SOCIAL SECURITY #:_____ - ___ - _____

SUBSCRIBER'S ADDRESS: _____ CITY: _____ STATE: _____ Z IP CODE: _____

HOME PHONE: (___) _____ WORK PHONE: (___) _____ BIRTH DATE: _____ SEX: _____MALE _____ FEMALE

SUBSCRIBER'S EMPLOYER: _____ ADDRESS: _____ CITY: _____ STATE: ____ ZIP CODE:_____

INSURANCE POLICY ID #: _____ GROUP #: _____ EFFECTIVE DATE OF INSURANCE: _____

DR. JEFFREY D. GABER
& ASSOCIATES, PA

PATIENT'S NAME _____ **DOB** _____
(Please Print)

INSURANCE ASSIGNMENT

PLEASE READ BEFORE SIGNING

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 insurance claim. 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.

I understand the charge of a non-participating physician may exceed the 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.

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

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 _____

PAYMENT
I will pay to Dr. Jeffrey D. Gaber and Associates any balance due for services rendered to me, or for any child over whom I am the parent or legal guardian. 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.

COLLECTION FEES
The undersigned expressly agrees that if, upon default, this matter is referred for collection, he/she agrees to pay a reasonable COLLECTION fee of thirty-five percent (35%), (for attorneys' fees and related costs of collection), 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.

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.

GUARANTY
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

SELF-PAY OBLIGATION

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 insurance/maintenance plan. If I receive any direct payments from my insurance carrier or any other payer for the purposes of payment of my medical bills for treatment with Gaber & Associates, PA, I agree to forward those amounts to Gaber & Associates, PA.

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.

If the patient is a minor and under my care, I am signing as the responsible party for any uncovered expense.

If the patient is an adult for whom I am the guardian, or over whom I have a financial power of attorney. I will take the proper actions within my power to make payment from the patient's funds on his or her behalf.

The undersigned expressly agrees that if, upon default, this matter is referred for collection, he/she agrees to pay reasonable COLLECTION fees of thirty-five percent (35%) for attorneys' fees and related costs of collection 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

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: _____

Witness: _____

DR. JEFFREY D. GABER & ASSOCIATES, PA

Patient – Provider E-mail and Patient Portal Communication Form

Keep in the Patient's Medical Record

I allow Dr. Jeffrey D. Gaber and Associates, PA to use electronic mail (e-mail) and the Patient Portal to communicate clinical information to me pertaining to health care services that I have received. I acknowledge and understand that e-mail and the Patient Portal 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 and my information in the Patient Portal 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. Despite our security efforts, it is also possible that the Pateint Portal could be accessed by third parties.*** In allowing Dr. Jeffrey D. Gaber and Associates, PA to send me these electronic means of communication, I assume this risk.

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

1. E-mail and the Patient Portal are 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 or the Patient Portal message have 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 message.
3. E-mail and Portal messages are NOT monitored 24/7 and responses can take up to 72 hours, if a response is NOT received, it is the patient's responsibility to contact the office to follow-up.
4. I will not use e-mail or the Patient Portal message 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 electronic communications, (e.g., lab results), it is my responsibility to notify Dr. Jeffrey D. Gaber & Associates, PA.
5. Employees of Dr. Jeffrey D. Gaber & Associates, PA other than the Provider may have access to my Patient Portal information, and 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.
6. I, and not the Provider or Dr. Jeffrey D. Gaber & Associates, PA, am responsible for the security of electronic communications sent from or stored on my computer.
7. My decision to allow Dr. Jeffrey D. Gaber and Associates, PA to communicate with me by any electronic means is voluntary, and that treatment is not conditioned upon my election to do so.
8. Gaber & Associates strongly discourages copying of email communications directed to the practice to any other person. If I choose to include a copy of any of my communications to Dr. Gaber or his staff, Dr. Gaber and staff will only respond to me. [unless the person to be copied is also on a medical Heath Care Directive on file with the practice office.
9. Dr. Jeffrey D. Gaber and Associates, PA or I may stop e-mail communication at any time for any reason.
10. I agree to notify the Dr. Jeffrey D. Gaber and Associates, PA when my e-mail address changes.
11. I will not hold Dr. Jeffrey D. Gaber & Associates, PA responsible for damages resulting from their use of e-mail, the Patient Portal, or the failure of any Dr. Jeffrey D. Gaber & Associates, PA's information systems used to facilitate the e-mail communication.
12. I understand that all emails related to my care received or generated by Dr. Jeffrey D. Gaber & Associates, PA may not be permanently stored. If an e mail is important to me, I am responsible for its storage

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:***	***E-mail Address:***

Patient Name (Print):	***Patient/ Patient Representative Signature:***	***Date:***

DR. JEFFREY D. GABER
& ASSOCIATES, PA

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS AND DISCLOSE PROTECTED HEALTH INFORMATION

PLEASE CIRCLE ANSWER

FROM / TO
Name/Practice:_____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

FROM / TO
Dr. Jeffrey D. Gaber & Associates
341 N. Calvert Street, Suite 300
Baltimore, MD 21202
410-986-4400 Phone
410-986-4411 Fax

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 above. 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 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). **Mark with an "X".**

	Consultation Reports		Operative Report
	Discharge Summary		Outpatient records
	Drug or Alcohol Treatment Records		Outpatient Surgery
	Emergency Room Records		Pathology Report
	Medical Records/Notes		X-ray Report
	Patient's Initials required for records indicated below		Other:
	Mental Health Records		**Patient Initials**_____
	Drug and Alcohol Treatment Records		**Patient Initials**_____

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. I understand that there will be a charge for copying and handling any record requests and that I will pay all fees in compliance with the standard office policy regarding the payment of records. T this authorization will expire in one year unless I revoke this authorization earlier. I understand that in order to pick up any copies of records I may be requested to present license or other positive identification. Records may be released in paper, or electronic form. Any records transmitted electrically (e.g. via email) are subject to the Practice's email communication policy.

This authorization expires on (upon) _____. If no date is indicated, this Authorization automatically expires one year from its date.

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____ _____
Print Name of Patient or Legal Guardian Date of Birth