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: _____

ADDRESS: _____ 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: (_____) _____ MINORS: MOM'S WORK PHONE (_____) _____
DAD'S WORK PHONE: (_____) _____

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

CURRENT EMPLOYER: _____ EMPLOYER AT TIME OF INJURY: _____

EMPLOYMENT STATUS: _____ FULL TIME _____ PART TIME _____ UNEMPLOYED _____ STUDENT _____ HOUSEWIFE/HUSBAND

NAME OF ATTORNEY _____

INSURANCE COMPANY _____

WORKER'S COMPENSATION / PERSONAL INJURY: ❑ Auto Accident ❑ Work Comp Accident

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 DESCRIPTION: _____

TOBACCO HISTORY NO ____ YES ____ #PACKS PER DAY ____ #YEARS SMOKED ____ QUIT? ____ WHEN? ____

BRIEF MEDICAL HISTORY

HIGH BLOOD PRESSURE _____ DIABETES _____ ULCERS _____ ARTHRITIS _____

HEART DISEASE _____ ASTHMA _____ CANCER _____ SURGERY _____

LAST MENSTRUAL PERIOD _____ BLEEDING _____ KIDNEY DISEASE_____ OTHER _____

CURRENT MEDICATIONS: _____

MEDICATION ALLERGIES: _____

PRIMARY CARE PHYSICIAN: _____ HAVE YOU BEEN A PATIENT OF THIS PRACTICE PREVIOUSLY? _____

HEIGHT _____ FT _____ INCHES WEIGHT _____ LBS

DR. JEFFREY D. GABER
& ASSOCIATES, PA

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS AND DISCLOSE PROTECTED HEALTH INFORMATION

PLEASE CIRCLE ANSWER

FROM / TO	**FROM / TO**
Name/Practice:_____	Dr. Jeffrey D. Gaber & Associates
Address_____	341 N. Calvert Street, Suite 300
City, State, Zip: _____	Baltimore, MD 21202
Phone: _____	410-986-4400 Phone
Fax: _____	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~~t~~his 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

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, or those provided to any child for whom I am the guardian, 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 or accept payment from my private health insurance or any governmental payor (e.g., Medicare, Medicaid, Tricare, etc.).

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 personally responsible for payment of these services in full.

STATUTE OF LIMITATIONS TOLLING AGREEMENT

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

Any applicable statutes of limitations, statutes of repose, or other defenses I may have relating from a delay of enforcement to any claim by Dr. Jeffrey D. Gaber & Associates, P.A. that is not otherwise barred as of the date of this waiver, shall be tolled for three years from the final date I have to enforce an injury claim, final settlement or the final, non-appealable award of damages related to the accident or injury I sustained, whichever is later.

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'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 Maryland Worker's Compensation Commission or its intermediaries or carriers, the Injured Workers Insurance Fund, any auto liability carrier or attorney, 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 injury benefits either to myself or to the party who accepts assignment below.

I understand that, without an authorization/referral from the insurance carrier or other responsible party, 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 any applicable insurance policy or other responsible party.

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 a responsible party. I will be responsible for any outstanding balance. Notwithstanding the foregoing, I understand that Dr. Gaber has agreed to accept any Worker's Compensation reimbursement as payment in full for his services.

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 unless otherwise agreed in writing or required by law.

SIGNATURE OF SPOUSE

Below I affix my seal.

Signature _____ Date _____

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. 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 in any forum, 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 a legal proceeding and acknowledge that such appearance is solely for my benefit and accept full responsibility for your fee associated with such appearance, such fees to be fixed at a rate of $800 per hour for Drs. Jeffrey D. Gaber and Jonathan Gitter and $850 hour for Dr. Douglas Shepard. I may also be charged for specialized reports prepared for, or at the request of my attorney, relating to any matter on which I have engaged a lawyer to assist me.

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 or judgment proceeds.

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, or from any responsible party, I agree to immediately make payment to Dr. Jeffrey D. Gaber & Associates, P.A. upon receipt of such monies.

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

Date: _____ Signature: _____

Address: _____ Witness: _____

City: _____ State: _____ Zip: _____

Day Phone Number: _____ Cell Phone Number: _____

Attorney's Name: _____ Phone Number: _____