



Dr. Jeffrey D. Gaber & Associates, PA

PATIENT INFORMATION EVALUATION SHEET - PLEASE PRINT - COMPLETE ALL INFORMATION

TODAY'S DATE: \_\_\_\_\_ LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ ZIP CODE \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

EMERGENCY CONTACT PERSON: \_\_\_\_\_ PHONE \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ MARRIED: \_\_\_ SINGLE: \_\_\_ WIDOWED: \_\_\_ DIVORCED: \_\_\_ SEX: MALE \_\_\_ FEMALE \_\_\_

EMPLOYMENT STATUS: \_\_\_ FULL TIME \_\_\_ PART TIME \_\_\_ UNEMPLOYED \_\_\_ STUDENT \_\_\_ HOUSEWIFE / HUSBAND

CURRENT EMPLOYER: \_\_\_\_\_ EMPLOYER AT TIME OF INJURY: \_\_\_\_\_

LIST ALL PREVIOUS EMPLOYMENT: \_\_\_\_\_

ATTORNEY'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

HIGHEST EDUCATION LEVEL: \_\_\_\_\_

TOBACCO HISTORY: NO \_\_\_ YES \_\_\_ : # PACKS PER DAY \_\_\_ # YEARS SMOKED: \_\_\_ QUIT? \_\_\_ WHEN? \_\_\_

DATE OF ACCIDENT: \_\_\_\_\_ WHAT PARTS OF YOUR BODY WERE INJURED: \_\_\_\_\_

DESCRIPTION OF ACCIDENT: \_\_\_\_\_

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

WERE X-RAYS TAKEN? \_\_\_\_\_ MEDICATION PRESCRIBED? \_\_\_\_\_

CURRENT COMPLAINTS: \_\_\_\_\_

ANY PRIOR INJURIES? IF YES, GIVE DATES AND DESCRIPTION: \_\_\_\_\_

BRIEF PERSONAL MEDICAL HISTORY:

HIGH BLOOD PRESSURE \_\_\_\_\_ DIABETES \_\_\_\_\_ ULCERS \_\_\_\_\_ ARTHRITIS \_\_\_\_\_

HEART DISEASE \_\_\_\_\_ ASTHMA \_\_\_\_\_ CANCER \_\_\_\_\_ SURGERY \_\_\_\_\_

LAST MENSTRUAL PERIOD \_\_\_\_\_ BLEEDING \_\_\_\_\_ KIDNEY DISEASE \_\_\_\_\_ OTHER \_\_\_\_\_

MEDICATIONS (FOR INJURY OR ANY OTHER REASON): \_\_\_\_\_

MEDICATION ALLERGIES: \_\_\_\_\_

HAVE YOU BEEN A PATIENT OF THIS PRACTICE PREVIOUSLY? \_\_\_\_\_

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.

**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.

**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 by the patient, on the same terms and conditions as the patient, as and when the same becomes due.  
**SIGNATURE OF SPOUSE Below I affix my seal.**  
Signature: \_\_\_\_\_ 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 in 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 statute of limitations.

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

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Address: \_\_\_\_\_ Witness: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

City State Zip Code

Day Phone Number: (\_\_\_\_) \_\_\_\_\_ Evening Phone Number: (\_\_\_\_) \_\_\_\_\_

Attorney's Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_



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

## 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)

- |  |   |
|--|---|
| <input type="checkbox"/> Consultation Reports              | <input type="checkbox"/> Operative Report   |
| <input type="checkbox"/> Discharge Summary                 | <input type="checkbox"/> Outpatient Records |
| <input type="checkbox"/> Drug or Alcohol Treatment Records | <input type="checkbox"/> Outpatient Surgery |
| <input type="checkbox"/> Emergency Room Records            | <input type="checkbox"/> Pathology Report   |
| <input type="checkbox"/> Medical Records/Notes             | <input type="checkbox"/> X-Ray Report       |
| <input type="checkbox"/> Mental Health Records             | <input type="checkbox"/> 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) \_\_\_\_\_

Signed By:

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

\_\_\_\_\_  
Date of Birth