Neil Spiegel, DO and Jennifer Gularson, PA-C
3200 Tower Oaks Blvd, Suite 430
Rockville, MD 20852
Phone) 301/231-5050 Fax) 877/781-0056

Date of Appointment: _____

Patient Name: _____

DOB: _____ Sex: M/F _____ Marital Status: _____

Race: (please circle) White, American Indian or Alaska Native, Native Hawaiian or Pacific Islander, Black or African American, Unknown
Ethnicity: Hispanic/Latino, Not Hispanic or Latino, Unreported or Refuse to Report

Address: _____
City: _____ State: _____ ZIP: _____
Primary Phone # _____ Home Cell Work
Secondary Phone # _____ Home Cell Work
Email: _____
Name of Employer/School/Retired _____
City and State: _____ Work # _____ Position/Grade _____

Preferred Method of Appointment Confirmation: TEXT EMAIL PHONE CALL (please circle)

Emergency Contact: Name, Phone and Relationship to patient
_____
Pharmacy Name, Phone, and Zip code:
_____
Who referred you?: _____

Reason for today's visit: _____

Responsible Party's Signature _____ Date: _____

Patient Name: _____ DOB: _____

HT: _____ WT: _____

Smoking History: Do you smoke? Y / N Have you ever smoked? Y / N

If Yes, how long did you smoke? _____ How many packs per day? _____

If quit, how long ago? _____ What method did you use to quit? _____

Please list all medications and supplements (or provide list):

Name	Dosage	Frequency	Prescriber

Please list any allergies and your reaction: If None circle - NO KNOWN DRUG ALLERGIES

Patient Name: _____ DOB: _____

FINANCIAL AGREEMENT

Patient: _____

Financial Responsible Party _____

I agree to be fully responsible for payment of services performed in this office including any and all amounts not covered by the insurance carrier or prepayment program that I, or the patient above may have. Please review your contract information about nonpayment, default, and or prepayments required prior to your scheduled.

_____

Signature of Financially Responsible Party

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

Use and Disclosure of Protected Health Information

Our notice of Privacy Practice states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations.

Please acknowledge receipt or reading of our Notice of Private Practices by initialing in the space below.

Patient initials: _____ Date: _____

By initialing this form, you consent to our use and disclosure of protected health information about your treatment, payment, and health operations. You have the right to revoke this consent in writing, except where we have already made disclosures in trust on your prior consent

MEDICARE PATIENTS ONLY

I request payment of authorized Medicare Insurance carrier benefits be made on my behalf to Dr. Neil Spiegel for any services furnished to me by his practice, unless the service I received was paid for in full at the time of service. I authorize any holder of medical information about me to be released to the Centers for Medicare Services and its agent and/or any other Insurances carriers for which I have coverage, that is needed to determine benefits for services received. I agree to provide all referral and treatment plans as required by my insurance carrier.

Print Name _____

Signature _____

Date _____

NO-SHOW / CANCELLATION POLICY

We understand that from time to time things may occur that will keep you from your scheduled appointment, but recently we have experienced a large increase in missed appointments. Due to this high no show/cancellation rate, we have instituted this policy. The decision to implement this policy was a difficult one, however we have found the large numbers of no show/ cancellations have adversely affected other patients.

Patients should make every attempt to arrive on time for their scheduled appointments. If you are unable to keep your appointment we ask that you give us at least **24** hours for an established patient and **72** hours for a new patient. This allows us time to fill that appointment slot. Depending on the providers caseload you may be asked to reschedule your appointment if you are more than 10 minutes late.

Fees for "missed appointments" are as follows:

1st "missed appointment" with a valid reason = no charge

1st "missed appointment" without a valid reason = $100 fee

2nd "missed appointment" = Full visit fee

Patients who miss more than 3 appointments will not be allowed to schedule an appointment in advance. These patients should call on the day they wish an appointment to see what openings are available.

Patients are to pay missed appointment fees prior to their next appointment.

Please sign and date below:
I, _____, understand and agree to the above policy. I understand that any fees I incur due to missed appointments are my sole responsibility and my insurance company cannot be billed. Furthermore, I understand that these fees must be paid in full prior to my next visit.

Signature: _____

Date: _____

Osteopathic Center for Healing
3200 Tower Oaks Blvd # 430
Rockville, MD 20852
Tel No. (301)231-5050 Fax No. (877)781-0056

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby give my informed consent to: **Neil Spiegel D.O. or Jennifer Gularson, PA-C**

___to disclose information to: _____

___to obtain information from: _____

___to exchange information with: _____

Regarding copies of and discussion related to the reports designated below: and for continuing coordination.

___Initial assessment
___Physician's Progress Notes
___Physical Therapy Progress Notes
___Laboratory Reports
___Other (specify) …….....
……

Client Name _____
Date of Birth _____
Purpose of Disclosure (describe) ……..

The consent will automatically expire one year from the date signed by the client or legal representative and may be revoked, in writing by the undersigned at any time.

_____ _____
Signature of Individual or Legal Representative Date

_____ _____
Signature of Witness Date

The above information was released /requested: _____
Date

_____
(Signature of the staff Member)

TO AGENCIES RECEIVING THE MEDICAL REPORT: **PROHIBITION OF REDISCLOSURE:** THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM A MEDICAL RECORD WHOSE CONFIDENTIALITY IS PROTECTED. ANY FURTHER REDISCLOSURE IS PROHIBITED.