Patient Information (Adult over 18)

File Number:	

Last Name:	First Name:	Middle Initial:

Date of Birth:	Age:		Gender: male: ☐ female: ☐

Street Address:

City:	State:	Zip Code:

Home Phone #:	Work Phone #:	Cell Phone #:

Name of Emergency Contact:	Phone Numbers & Address of Emergency Contact:	Relationship:

Authorizations

I authorize Dr. Angela Gabella to treat me ____ initial

I authorize all payments to be made directly to Dr. Angela Gabella on the day of service. I consent to the release of all information the insurance company may request for filing their claims. I understand that I am responsible for billing my insurance company, but many insurance companies do not cover all charges and that I am responsible for and will pay for all charges on the date of services provided by Dr. Angela Gabella ____ initial

I have received and reviewed the handout called Privacy Practices Notice. I understand that I can ask for further information if needed ____ initial

Another practitioner referred me to Dr. Gabella. I authorize Dr. Gabella to send a report of her findings to ____ initial

Practitioners Name: _____

Discipline: _____

Phone Number: _____

Our primary relationship is with you, the patient, not the insurance company. Given that we accept your case, our recommendations will be based upon what your needs are & what we believe is best for you.

I understand and agree to the following:
There is no guarantee that my health insurance plan or policy will pay for all or part of my care. As the patient or guardian of a patient, I am ultimately responsible for all charges incurred from services rendered at Gabella Brain and Spine Clinic LLC.

Patient's signature (*or guardian's signature*): _____. Date:_____