120 E. Main St. Ste. B
Payson, AZ 85541
928-472-2225

NEW PATIENT INTAKE FORM

Last Name: _____First Name:_____MI:_____

Date of Birth: _____ Age: _____ Gender: _____Male _____Female

Mailing Address: _____

City: _____ State: _____ Zip: _____

Contact Phone No: _____ (Check One) Cell: _____ Home: _____ Email

Address: _____ (Please provide)

How did you hear about the clinic?_____

Height: _____ Weight: _____ Nationality: _____

Employer:_____ Employer Number: _____

Marital Status: (Please circle): Single Married Separated Divorced
With Partner Widow(er)

Emergency Contact Name: _____ (Please Provide)

Emergency Contact Number: _____ (Please Provide)

Relationship to Emergency Contact:_____

Insurance Information

Policyholder's Name:_____

Policyholder's SSN: _____ Policyholder's DOB: _____

Relationship to Patient: _____ Driver's License:_____

Policy Number: _____ Name of Insurance: _____

GABBERT MEDICAL

PATIENT INTAKE FORM

Name:

Date of Birth:

CONCERNS

Thank you for taking the time to fill out this intake form. We know it's comprehensive, but by gathering this information about your health history and goals helps give your doctor a more complete understanding of you. We want to help you reach your optimal health.

Most important concern you would like to address?

Additional concerns?

FAMILY HISTORY

Have any blood relatives ever had any of the following?

☐ Cancer	☐ Tuberculosis
☐ Asthma	☐ Mental Illness or suicide
☐ Diabetes	☐ High Blood Pressure
☐ Allergies	☐ Autoimmune Disease
☐ Heart Attack	☐ Heart Disease
☐ Stroke	☐ Osteoporosis
☐ Other	

If YES, check appropriate box and please indicate who below (maternal aunt, paternal grandmother, father, son, sister, etc)

MEDICAL HISTORY

Who is your Primary Care Physician? Please include address, phone number, and fax number.

Please indicate the doctors or practitioners that have been involved in your care in the last three years.

☐ Acupuncturist	☐ Chiropractor
☐ Gastroenterologist	☐ Hematologist/Oncologist
☐ Surgeon	☐ Endocrinologist
☐ Cardiologist	☐ Naturopathic Physician
☐ Gynecologist	☐ Other

List any significant prior illnesses, diagnoses, or injuries, including date occurred (ie. hypertension, March 2015)

List all surgeries and hospitalizations, including reason and date occurred?

Please list any major accident or illness during childhood not already indicated?

Date of last physical exam?

Date of last blood work?

Medical Imaging

X-ray: Provide date, area of body, and reason?

MRI/CAT Scan: Provide date, area of body, and reason?

Ultrasound: Provide date, area of body, and reason?

Vaccination History

Have you ever had the disease (D), been immunized (I), neither (N) or unknown (U) for the following?

	D	I	N	U	Date
Tetanus	o	o	o	o	
Whooping cough (Pertussis)	o	o	o	o	
Hemophilus (HiB)	o	o	o	o	
Hepatitis A	o	o	o	o	
Hepatitis B	o	o	o	o	
Measles	o	o	o	o	
Mumps	o	o	o	o	
German Measles (Rubella)	o	o	o	o	
Chicken Pox	o	o	o	o	
Shingles	o	o	o	o	
Human papilloma virus (HPV)	o	o	o	o	
Pneumococcal Conjugated Vaccine (PCV)	o	o	o	o	
Polio	o	o	o	o	
Meningococcal	o	o	o	o	
Pneumonia	o	o	o	o	
Influenza	o	o	o	o	
Other Vaccines	o	o	o	o	

Any adverse reactions to any vaccinations?

- ☐ No
- ☐ Yes, describe:

Medications / Supplements

Current Medications and Supplements (please include ALL prescriptions, over-the-counter drugs, vitamins, herbs, etc.). Please include daily dose and reason for taking it.

Allergies

Please indicate allergies?

- ☐ No known allergies
- ☐ Medication
- ☐ Foods
- ☐ Environmental

Please indicate allergy and describe reaction:

SOCIAL HISTORY

What is your current job?

Do you enjoy your job? ☐ Yes ☐ No

What are your hobbies?

Have you done any foreign travel within the last year?

☐ Yes, indicate where ☐ No

Please indicate your average level of energy throughout the day using the scale 1-10 (1 is the lowest and 10 is the highest)

Do you exercise? If YES, indicate type of exercise, how many days per week, and for how long? (i.e. bicycling, 3 days, 60 minutes)

☐ Yes, describe ☐ No

Sleep

How many hours of sleep do you usually get per night?

Do you wake feeling refreshed?

☐ Always ☐ Usually ☐ Rarely ☐ Never

Do you have difficulty sleeping?	☐ Yes	☐ No
Any trouble falling asleep?	☐ Yes	☐ No
Any trouble staying asleep?	☐ Yes	☐ No
Do you snore?	☐ Yes	☐ No
Do you have nightmares?	☐ Yes	☐ No

Do you need a sleep-aid?

☐ Yes, indicate what ☐ No

Alcohol, Tobacco, and Recreational Drug Use

Do you drink alcohol?

☐ Daily ☐ Weekly ☐ Monthly ☐ No

What type of alcohol do you prefer? ☐ Liquor ☐ Wine

☐ Rarely ☐ Never

How much do you drink per sitting? Indicate amount consumed per occasion.

Do you smoke tobacco?

☐ Yes ☐ No ☐ In the past

If yes, how many cigarettes or packs per day?

If past, when did you quit smoking, number of years smoking, and packs per day?

Do you use recreational drugs?

☐ Yes ☐ No ☐ In the past

If yes, how often?

☐ Daily ☐ Weekly ☐ Monthly ☐ Other

If Yes or in the past, what kind?

Have you ever been told you have an addiction or been treated for an addiction?

☐ Yes ☐ No

Does the use of alcohol or drugs impair your activities of daily living?

☐Yes ☐No

Diet

Do you follow a special diet (ie South Beach, Paleo, Vegan, Blood-type, etc.)?

☐ Yes, indicate type ☐ No

How many ounces of water do you drink each day?

How many meals do you eat a day?

Do you drink energy drinks?

☐Daily ☐Weekly ☐Monthly ☐ No

Please indicate what kind of energy drink and how much:

Do you drink soda, juice or sports drinks?

☐Daily ☐Weekly ☐Monthly ☐ No

Please indicate what kind of soda, juice or sports and how much:

How many 8oz cups of coffee do you drink daily?

Relationship

Relationship status?

☐ Single ☐ Separated
☐ Married ☐ Divorced
☐ Domestic partner ☐ Widowed
☐ In a relationship ☐ Other

Are you satisfied with your significant relationships?

☐ Yes ☐ No

Do you find your life?

☐ Satisfactory
☐ Unsatisfactory
☐ Boring
☐ Too demanding

Do you live alone?

☐ Yes ☐ No

Do you have a support system?

☐ Strong ☐ Moderate ☐ Limited

Major stressors in the last year?

☐ Money
☐ Job
☐ Marriage/relationship
☐ Home life
☐ Children
☐ Loss
☐ Other

Do you have a history of abuse? Check all that apply.

☐ Mental abuse
☐ Physical abuse
☐ Sexual abuse
☐ Emotional abuse

If yes, by whom and at what age?

How would you define your childhood memories?

☐ Mostly happy
☐ Normal
☐ Mostly painful
☐ Denies recollection

Review of Symptoms

MUSCULO-SKELETAL
_____ Low back problems
_____ Pain between shoulders
_____ Neck problems
_____ Arm problems
_____ Leg problems
_____ Swollen joints
_____ Painful joints
_____ Stiff joints
_____ Sore muscles
_____ Weak muscles
_____ Walking problems
_____ Broken bones

CARDIO-VASCULAR
RESPIRATORY
_____ Chest pain
_____ Pain over heart
_____ Difficulty breathing
_____ Persistent cough
_____ Coughing phlegm
_____ Coughing blood
_____ Rapid heartbeat
_____ Blood pressure problem
_____ Heart problems
_____ Lung problems
_____ Varicose veins

NERVOUS SYSTEM
_____ Numbness
_____ Loss of feeling
_____ Paralysis
_____ Dizziness
_____ Fainting
_____ Headaches
_____ Muscle jerking
_____ Convulsions
_____ Forgetfulness
_____ Confusion
_____ Depression

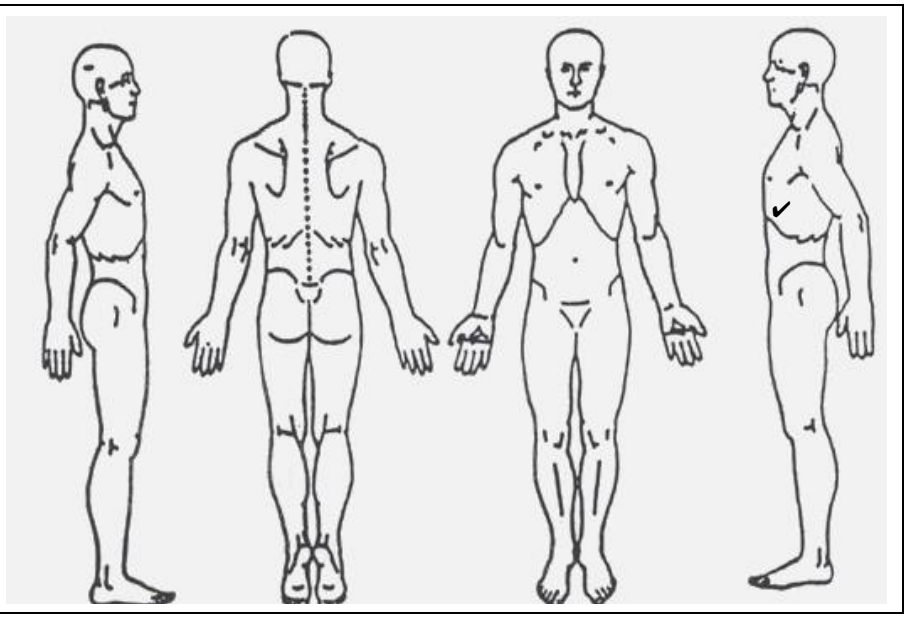
GENITO-URINARY
_____ Bladder trouble
_____ Excessive urine
_____ Scanty urination
_____ Painful urination
_____ Discolored urine

FEMALE
_____ Vaginal discharge
_____ Vaginal bleeding
_____ Vaginal pain
_____ Breast pain
_____ Lumps on breast(s)
Are you pregnant/nursing?
_____Yes _____No

GASTRO-INTESTINAL
_____ Poor appetite
_____ Excessive hunger
_____ Difficulty chewing
_____ Difficulty swallowing
_____ Excessive thirst
_____ Nausea
_____ Vomiting food
_____ Vomiting blood
_____ Abdominal pain
_____ Diarrhea
_____ Constipation
_____ Black stool
_____ Bloody stool
_____ Hemorrhoids
_____ Liver trouble
_____ Gallbladder problems
_____Weight trouble

EYES, EARS, NOSE
& THROAT
_____ Eye strain
_____ Eye inflammation
_____ Vision problems
_____ Ear pain
_____ Ear noises
_____ Hearing loss
_____ Ear discharge
_____ Nose pain
_____ Nose bleeding
_____ Nose discharge
_____ Difficult nose breathing
_____ Sore gums
_____ Dental problems
_____ Dental problems
_____ Difficult speech

INDICATE AREAS OF PAIN BELOW:



OTHER HEALTH CONCERNS:

_____
_____
_____
_____
_____
_____
_____
_____

Patient/Responsible Party: _____ **Date:** _____

Signature: _____

Your signature confirms that the information provided is current and accurate.

GABBERT MEDICAL
120 E. Main Street, Suite B |Payson, Az 85541
P: 928-472-2225 | **F:** 928-468-0002
www.GabbertMedical.com

CONSENT TO TREAT FORM

CHIROPRACTIC TREATMENT

Chiropractic care is a non-surgical, non-invasive procedure and has one of the safest records in health care. As with any healthcare specialty, we cannot promise a cure, but we will give you our best care and we will discuss any questions or concerns with you.

Patients may experience temporary symptoms such as an increase in soreness following a massage, manipulation or traction. In addition, physiotherapy such as ice, heat or ultrasound may irritate the skin. There have been a few cases where adjustments may have aggravated a bulging or herniated disc or caused a rib fracture. On extremely rare occasions, adjustments to certain areas of the cervical spine have been related to a compromise of the vertebral artery and possible stroke symptomatology.

I acknowledge that I have discussed non-surgical Chiropractic care and physiological therapeutics and by signing below I authorize Gabbert Medical to provide such care.

PRIMARY CARE TREATMENT

Primary care focuses on comprehensive, patient-centered medical care aimed at the prevention, diagnosis, and treatment of a wide range of health conditions. It is often the first point of contact for patients and plays a vital role in managing overall health and coordinating any specialty care needed.

Care provided by the providers and staff at Gabbert Medical may include routine physical exams, diagnostic testing, laboratory work, management of chronic conditions (such as diabetes, hypertension, and asthma), acute illness treatment, immunizations, preventive screenings, medication management, and health education.

I consent to receiving primary care treatment, which may include, but is not limited to lifestyle counseling, medication prescriptions, diagnostic and screening tests, immunizations, minor procedures, and referrals to specialists when medically indicated.

I understand that, as with all medical treatments, there may be risks involved, which can include, but are not limited to pain, discomfort, minor bruising or bleeding at injection sites, dizziness, allergic reactions to medications or vaccines, or aggravation of existing symptoms. I acknowledge that my provider will discuss any significant risks with me before initiating a treatment or procedure.

MEDICAL RECORDS PROTOCOL

Gabbert Medical is in accordance with Arizona State Law and maintains medical records for a period of at least six (6) years after the last treatment date. Minor patient's records are maintained for a period of at least three (3) years after the child's 18th birthday or for at least six (6) years after the last treatment date, whichever occurs later. Gabbert Medical has a protocol for the secure storage, transfer, disposal and access of medical records at our office. By singing below I acknowledge that I

have been provided a copy of the ***Medical Records Protocol*** for Gabbert Medical and is available to me at any time upon request.

RECORD RELEASE

I understand that my records and X-Rays may be released for professional consultations to other health providers as necessary. Gabbert Medical routinely sends many X-Rays and related health care information to Diagnostic X-Ray Consultation Services for interpretation. Should additional consultations be required with other HealthCare providers (i.e. Orthopedists, Neurologist, etc.) records will be provided as necessary. I also understand that my records and X-Rays may be released for payment purposes to Insurance Companies, Attorneys, and/or other third parties as necessary to obtain payment. By singing below I authorize the release of my records and X-Rays for these purposes. I understand that all my records will be kept confidential and will not be released without my written consent.

NOTICE OF PRIVACY PRACTICES AND HIPPA

Gabbert Medical in accordance with HIPAA regulations wants to protect your rights and privacy as a patient. In addition, we will not provide your medical records to any outside third party for independent marketing purposes. All medical records are stored in compliance with Arizona State Law. Any questions regarding Privacy Practices may be directed to the Clinic Director, Dr. Brian Gabbert who serves as the Privacy Officer. By signing below, I acknowledge that I have been provided with a copy of or made aware of our ***HIPPA and Notice of Privacy Practices*** for Gabbert Medical (PP-09- 23-13) that are made available to me at any time upon request and in no way affects the care I receive at Gabbert Medical. By signing below, I authorize Gabbert Medical to provide such care.

PATIENT FINANCIAL POLICY AND AUTHORIZATION

Thank you for allowing Gabbert Medical to be your health care provider. We are committed to providing you with the highest quality medical care, in a supportive, empathetic, and respectful manner. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional medical services. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities.

Carefully review the following information and return this form to us with your signature and today's date.

INSURANCE

It is imperative that you provide us with current and accurate insurance information **at the time of your appointment.** We will scan a copy of your insurance card(s) at the time of your visit. If you fail to provide **ACTIVE AND VALID** insurance information, you will be considered self-pay and payment will be required in full prior to your appointment.

We will file your claims for you. However, it is important for you to understand that you have the contract with your insurance carrier, and you will need to help us work with your insurance carrier to expedite the reimbursement process. We will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary. As the patient, you are

responsible for any unpaid balance not contractually covered by your insurance. You have final responsibility for payment for services provided. Your participation in the process is both essential and encouraged.

If we DO participate with your insurance company, all services performed in our office will be submitted to them, unless we have received prior notification of non-covered services. All copays, deductibles, and coinsurances are the patient's responsibility and expected to be paid in full prior to treatment.

Not all services are a covered benefit in all contracts. Insurance companies select services they will not cover. It is your responsibility to know if a certain procedure is not covered; please verify any service(s) with your insurance carrier. We will also assist in checking your benefits. It is your responsibility to bring and share any required referrals for treatment at, or prior to, the visit. If you do not have the referral, your visit may be rescheduled, or you may be financially responsible.

PAYMENTS

ALL OUT-OF-POCKET COSTS WILL BE COLLECTED IN FULL AT TIME OF SERVICE. This includes, but is not limited to, patient responsibility of copays, deductibles, coinsurances, and self-pay patients.

Your insurance company requires us to collect co-payments at the time of service. For your convenience we accept cash, check, or credit card (MasterCard, VISA, AMEX, or DISC). If you are unable to make payment at the time of your visit, you may be asked to reschedule your appointment, except in case of a medical emergency.

SELF-PAY

Patients who do not have insurance coverage are self-pay. Self-pay patients are expected to make payment in full prior to visit and treatment. As a courtesy, the practice offers a discount of billed charges, to anyone with no insurance if prompt payment in full is received in advance of treatment. Discounts may not be given if payment in full is not received prior to treatment.

UNPAID BALANCES & PAYMENT ARRANGEMENTS

If your insurance company has not paid the balance in full or you are unable to pay the balance in full, you will receive a statement notifying you of the amount due. The statement will direct you to pay your balance on our payment portal. You may call our billing office at (785) 537-9030, option #6 for any questions on your account. Gabbert Medical reserves the right to set the terms, conditions, and to charge interest for any payment arrangement.

If you fail to make payment in full, within 90 days, for the services rendered to you, your outstanding balance may be considered for further collection activity. Should it become necessary for Gabbert Medical to send a patient's account to a collection agency, the patient will be responsible for all fees associated with the collection efforts of the account, to include reasonable attorney fees, court costs, collection charges, and interest.

COLLECTIONS/BANKRUPTCY

Gabbert Medical will require payment in full in advance of treatment for any patient who is in collections and/or who files bankruptcy. Gabbert Medical reserves the right to dismiss patients for lack of payment.

WAIVER OF PATIENT RESPONSIBILITY
It is the policy of the practice to treat all patients in an equitable fashion related to account balances. The practice will not waive, fail to make reasonable collection efforts, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payors

RETURNED CHECKS
The charge for a returned check is $30, payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a "Cash Only" basis following any returned check.

MINORS
If the patient is a minor (under 18 years of age), the parent(s) or guardian(s) is responsible for full payment and will receive the billing statements.

DIVORCE DECREES
Gabbert Medical is not party to any divorce decrees, so any outstanding balance is still the responsibility of the legal guarantor of the patient.

MEDICAL RECORD COPIES
Your medical record is the property of Gabbert Medical. If you would like to request a copy of your medical records, for yourself or to be mailed to another provider, please request via our patient portal, or contact our office at (785) 537-9030, option #1 to obtain the proper Medical Records Request form. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) THE CLINIC may charge a reasonable cost-based fee pursuant to 45 CFR 164.524.

COMPLIANCE WITH THE "NO SURPRISE ACT"
Your Rights and Protections Against Surprise Medical Bills:
When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")? When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit. "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're never required to give up your protection from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

If you think you've been wrongly billed, contact the Arizona Insurance Department at 800-432-2484. The federal phone number for information and complaints is: 1-800-985-3059.

PATIENT ACKNOWLEDGEMENT & AUTHORIZATIONS

Authorization for Release of Information: With your signature below, Gabbert Medical is hereby authorized to release a complete report of services rendered, diagnosis, findings and details of treatment and progress for the purpose of receiving payment for such services rendered. Recipients of such information may include authorized billings agents, insurance carriers, other third-party payers, the Social Security Administration under Title XVIII, XIX, and XXI of the Social Security Act, Professional Review Organizations, or other intermediaries responsible for payment for services rendered. The release of information consent may be revoked at any time by giving written notice. If the release of information is refused, the patient will be held responsible for payment of all charges for services rendered.

Authorization for Assignment of Benefits: In consideration of medical services provided, with your signature below, Gabbert Medical is given all rights, title, and interest to the medical reimbursement in accordance with the terms and benefits of the patient's insurance policy or other health benefits. The patient will be fully responsible for payment of all charges not covered by insurance.

Authorization for Treatment: With your signature below, Gabbert Medical is hereby authorized to conduct examinations, perform procedures, laboratory and other testing as are medically required and administer treatment and medications as deemed necessary or advisable.

Gabbert Medical must emphasize that as healthcare providers, our relationship is with you, not your insurance company. While filing the insurance claims is a courtesy we extend to our patients, all charges are strictly your responsibility from the time services are rendered. Therefore, it is often necessary for you to inquire about and explore your benefits with your insurance carrier. We do realize that temporary financial problems may affect timely payment, but if such problems do arise, we encourage you to contact us promptly for assistance in the management of your account at (785) 537-9030, option #6.

Gabbert Medical believes that a good patient-to-provider relationship is based upon understanding and good communication. Thank you for understanding our "Patient Financial Policy". We appreciate the opportunity to provide you with your health care needs. Your assistance and cooperation will be most appreciated.

Patient Print Name:_____ **Date:**_____

Signature of Patient or Responsible Party:_____

Relationship to Patient: _____

GABBERT MEDICAL
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OFFICE POLICIES

OFFICE HOURS
Our office is open Monday, Tuesday, Thursday, and Friday from 9:00 am to 6:00 pm. Patients are not scheduled from 1:00 pm through 2:00 pm during lunch. We are closed in observance of all major holidays.

NEW PATIENTS
For purposes of maintaining continuity of care, we ask that first-time patients bring us the latest relevant records with the most recent test results, MRI / CT / XRAY/BLOOD WORK and current medications list. We do ask that you remain the sole custodian of your entire medical records from your previous healthcare providers. Should there be a need to further examine your previous records, our providers will have you bring your records back for additional review during subsequent office visits.

COURTESY
We strive to provide the best medical care for our patients. While we make every effort to provide prompt on- time service, the healthcare needs of everyone do not necessarily lend themselves to an exact schedule. We therefore appreciate your understanding and patience if you must wait a few extra minutes. If you have any suggestions or complaints about our office, please let us know. Angry or foul language directed at our staff regardless of the issues involved will not be tolerated and will be grounds for immediate dismissal from our practice.

SUPERVISION OF CHILDREN & MINORS PRESENT WITHOUT PARENTS OR LEGAL GUARDIAN
Although we provide an area for children to entertain themselves, for safety reasons, we depend on parents to always supervise their child(ren). Our staff cannot watch your children. Under no circumstances should a child under the age of 10 be left unattended. We also require a consent form signed by a parent or legal guardian to legally provide medical care to minors 16 and 17 years of age when the parent or legal guardian cannot be present. Minors 15 years of age or younger must be accompanied by a parent or legal guardian.

CHANGES IN ADDRESS, BILLING, OR CONTACT INFORMATION
Please notify our office in writing of any changes to address, telephone, billing or contact information. It is imperative that we have the most current information on file.

APPOINTMENTS AND NO SHOW
We make every effort to provide prompt medical care for all our patients. If you are unable to keep a scheduled appointment, please let us know at least 24 hours in advance. A NO SHOW is when a patient fails to keep a scheduled appointment and does not give an appropriate amount of notice time. If you have a special circumstance regarding your missed appointment, please contact our office manager. We understand that there may be issues beyond your control and want to be understanding of special circumstances. If you are delayed and cannot make an appointment on time, please call to advise us of your situation and provide an estimated time of arrival. Any significant delay may require the visit to be rescheduled. Should you have more medical issues that need to be addressed, please inform our staff when calling for appointments, and we will schedule more time for you accordingly. Multiple family member appointments must be scheduled in advance. Family members who are present at the time of another member's appointment, but are not scheduled, may be required to schedule an appointment later.

TELEPHONE MESSAGES & PROCESSING REFERRALS
We will try our best to respond to your messages as soon as possible. However, please be aware that messages may take up to 24 HOURS to process and respond. If your questions require extensive attention, the doctor may have you

make an appointment and come for further evaluation for quality assurance purposes.

MEDICAL RECORDS & FORMS

All requests for medical records must be on a HIPPA approved form, which must be properly filled out and signed by the patient or legal guardian. Improperly filled out forms may delay your request. Please allow at least 10 BUSINESS DAYS for processing. Medical records released to a new provider, specialist or school: For continuity of care and as a courtesy to the patient, our office will forward records requested at no charge. Medical records released to the patient, some insurance companies, law firm or miscellaneous requests: Records are subject to copying fees.

IN A LIFE-THREATENING SITUATION, PLEASE CALL 911 IMMEDIATELY.

Our friendly staff is committed to making your visit as pleasant as possible. Your comments or concerns are important to us. We rely on them to continue to improve our quality medical care for you and your family.

By signing below, I understand and agree to the office policies and procedures explained above. A copy of the office policies and procedures along with notice of privacy information regarding Gabbert Medical will be available to me upon request.

Patient Print Name:_____ **Date:**_____

Signature of Patient or Responsible Party:_____

Relationship to Patient: _____