Gabbert Medical
120 E Main Street, STE B
Payson, AZ 85541-5618
Phone: (928) 472-2225
Fax: (928) 468-0002
info@GabbertMedical.com

CHIROPRACTIC & PRIMARY CARE
NEW PATIENT INTAKE FORM

Patient Demographics (Please fill in as much as possible)

Legal Last Name:_____ First Name: _____ Middle Initial: _____

Preferred Name: _____ Date of Birth: _____ Age:_____ Sex at Birth: ☐Male ☐Female

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Secondary Number: _____

Email Address: _____ Preferred Contact: ☐Phone ☐Text ☐Email

Height: _____ Weight_____ How did you hear about us? _____

Relationship Status: (Please check) ☐Single ☐Married ☐ With Partner ☐Separated ☐ Divorced ☐Widow(er)

Occupation: _____ Hours Per Week: _____

Employer: _____ Employers Phone: _____

Are you a Veteran? ○Yes ○No Disability accommodation needed? ○Yes ○No Housing: ○Stable ○Temporary ○No Fixed Address

Nationality: _____ Preferred Language: _____

Interpreter/Communication Assistance needed? ○Yes ○No Type/Language: _____

Do you have any Advance Directives (living will / Power of Attorney)? _____

Emergency Contact Name: _____ **Relationship**: _____

Emergency Contact Number: _____

INSURANCE INFORMATION

Payment Type: ☐Insurance ☐Self-Pay ***Please present current insurance card(s) and photo ID at check-in.***

Policyholder's Name: _____ Relationship to Policyholder: _____
Policyholder's SSN: _____ Policyholder's DOB: _____

Name of Insurance **(Primary)**: _____ Policy Number: _____
Member ID: _____

Name of Insurance **(Secondary)**: _____ Policy Number: _____
Member ID: _____

MEDICAL INFORMATION

(Reason for today's visit & current concerns)

Type of Care: ☐ Chiropractic ☐Primary Care ☐Both

Chief Complaint

Primary reason for visit / most important concern you would like to address:

_____

_____

When did this problem begin? _____ Pain / symptom level (0-10) _____

Was this related to an accident or injury? ○Yes ○No Date: _____

☐ Work-Related ☐Auto Accident ☐ Other Accident / Liability ☐Not Accident-Related

What makes the condition better? _____

What makes the condition worse? _____

Areas of Concern

Check all that apply:

☐ Headache / Migraine
☐ Neck
☐ Upper Back
☐ Mid Back
☐ Low Back
☐ Hip - Left
☐ Hip - Right
☐ Knee - Left
☐ Knee - Right

☐ Shoulder - Left
☐ Shoulder - Right
☐ Arm / Elbow - Left
☐ Arm / Elbow - Right
☐ Wrist / Hand - Left
☐ Wrist / Hand - Right
☐ Ankle / Foot - Left
☐ Ankle / Foot - Right

☐ Weakness
☐ Numbness / Tingling
☐ Balance / Dizziness
☐ Chest Symptoms
☐ Abdominal Symptoms
☐ Urinary Symptoms
☐ Skin Concern

Other concerns: _____

What makes the condition better? _____

What makes the condition worse? _____

CURRENT CARE / RECENT TESTING

Current Primary Care Provider: _____ Date of Last Visit: _____

Name of Practice / City: _____

Specialists seen in the past year: ☐ Cardiology ☐Orthopedics ☐ Pain ☐GI ☐Other _____

Most recent specialist / reason: _____

Imaging in the past 12 months: ☐ X-Ray ☐MRI / CT ☐ Ultrasound

Areas and date of imaging: _____

PERSONAL HEALTH HISTORY

Medical Conditions

Check all conditions that you currently have or have had in the past.

☐ High Blood Pressure
☐ Heart Failure
☐ Heart Murmur
☐ Heart Attack / Coronary Disease
☐ Stroke / TIA
☐ Seizure Disorder
☐ High Cholesterol
☐ Diabetes
☐ Liver Disease / Hepatitis
☐ Kidney Disease
☐ Tuberculosis
☐ Cataracts
☐ Glaucoma
☐ Cancer

☐ Migraines / Chronic Headaches
☐ Arthritis
☐ Chronic Pain
☐ Disc Disease / Herniation
☐ Joint Replacement
☐ Neuropathy
☐ Osteoporosis
☐ Scoliosis
☐ Spinal Stenosis
☐ Prior Fracture
☐ COPD / Chronic Lung Disease
☐ Asthma
☐ Gout
☐ Balance / Fall Problems

☐ Thyroid Disorder
☐ Autoimmune Disease
☐ Fibromyalgia
☐ Anemia
☐ Blood Clot / Bleeding Disorder
☐ Abnormal / Heavy Periods
☐ Pregnancy-Related Condition
☐ Prostate Condition
☐ Sexually-Transmitted Infection
☐ HIV / AIDS
☐ Anxiety
☐ Depression
☐ Other Mental Health Condition

☐ Other Condition(s): _____

Dates / Details: _____

PAST SURGERIES / HOSPITALIZATIONS

Year / Date	Surgery / Hospitalization	Reason	Facility Name / Location

MEDICATIONS, ALLERGIES & PHARMACY

Medications/Supplements

Please list ALL CURRENT prescriptions, medications, over-the-counter drugs, supplements, vitamins, herbs etc. Include daily dose and reason for taking it. Please note if medications are in need of a refill / new prescription.

Name of Medication, Supplement, etc.	Dosage	How Often / Instructions	Prescriber / Supplier	*If Medication:* Is a Refill needed?	30 or 90-day Supply

☐ No current medications or supplements.

ALLERGIES

☐ No Known Food or Drug Allergies.

Medication Allergies / Reactions: _____

Food Allergies / Reactions: _____

Environmental Allergies / Reactions: _____

Other Allergies / Reactions: _____

PHARMACY

Preferred Pharmacy (primary): _____ City: _____

Additional / Secondary Pharmacy: _____ City: _____

Controlled Substance Agreement with Another Provider? ☐ No ☐ Yes

If Yes, Name of Provider / Location: _____

SOCIAL, FAMILY & PREVENTIVE HEALTH

Health Habits & Social History

Do you exercise or work out? ☐ No ☐ Daily ☐ Weekly ☐ Monthly ☐ Other: _____
Intensity ☐ Light ☐ Moderate ☐ High ☐ Other: _____

Do you drink alcohol? ☐ No ☐ Daily ☐ Weekly ☐ Monthly ☐ Social ☐ Other: _____

Average Drinks / Week: _____

Do you use tobacco / nicotine? ☐ Never ☐Yes ☐ Social ☐ In the past Quit Year: _____

What type? ☐ Chew ☐Cigarettes ☐ Cigars ☐ Vape Amount Per Day: _____

Do you use recreational drugs? ☐ Never ☐ Yes ☐ Social ☐ In the past Type(s):_____

If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other: _____

Caffeine? ☐ Never ☐ Yes ☐ Social ☐ In the past Type(s):_____ Quit Year: _____

If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other: _____ Amount: _____

Family History

Have any blood relatives ever had any of the following?
If YES, please indicate who (mother, father, maternal grandfather, son, sister, etc.)

☐ Allergies (include type) _____
☐ Asthma (include type) _____
☐ Autoimmune Disease (include type) _____
☐ Cancer (include type) _____
☐ Diabetes (type I or II) _____
☐ Heart Attack / Coronary Disease _____
☐ Heart Disease _____
☐ High Blood Pressure _____
☐ Mental Illness / Suicide _____
☐ Osteoporosis _____
☐ Stroke _____
☐ Tuberculosis _____
☐ Other _____

Do you have any history of abuse? ☐ Physical Abuse ☐ Sexual Abuse ☐ Emotional Abuse ☐ None

Additional information

Is there anything else you would like your doctor to know about you / your family history?

_____

_____

PREVENTIVE CARE / IMMUNIZATIONS

(Please enter approximate dates for the following)

VACCINATIONS:

Flu:	COVID-19:
Tetanus:	HPV:
Pneumonia:	Shingles:
Other:	

Last Physical Exam: _____

Last Blood Panel: _____

Screening History (If Applicable)

Colonoscopy: _____ Result:_____

Stool Test: _____ Result:_____

Mammogram: _____ Result:_____

Pap Test: _____ Result:_____

Bone Density: _____ Result:_____

SEXUAL / REPRODUCTIVE HEALTH

Last Day of Last Menstrual Period (if applicable): _____ Could You Be Pregnant? ☐ No ☐ Yes ☐ N/A

Are You Sexually Active? ☐ No ☐ Yes ☐ Prefer not to answer

Sexual Partner(s)? ☐ None ☐ Men ☐ Women ☐ Both ☐ Prefer not to answer ☐ Other: _____

Number of Partners in the Past Year: _____

Pregnancy Prevention Used? ☐ No ☐ Yes ☐ N/A

History of STI? ☐ No ☐ Yes ☐ Prefer not to answer If yes, what type: _____

STI Protection Used: _____

If female, are you on Birth Control? ☐ No ☐ Yes If yes, what type: _____

ADDITIONAL INFORMATION

Is there anything else you would like your healthcare team to know?

_____

_____

Patient / Guardian initials confirming the health history is complete to the best of your knowledge _____

MEDICARE SECONDARY PAYER (MSP) QUESTIONNAIRE

Complete this page ONLY IF YOU HAVE MEDICARE. This helps determine if another payer should be billed before Medicare.

1. Are you receiving benefits from any of the following programs?

Black Lung: ☐ No ☐ Yes

Research Grant: ☐ No ☐ Yes

Veteran Affairs: ☐ No ☐ Yes

2. Was the illness / injury due to a work-related accident / condition?

☐ No ☐ Yes Date of injury / illness: _____

3. Was illness / injury related to a non-work-related accident?

☐ No ☐ Yes Date of accident: _____

What type of accident caused the illness / injury?

☐ Automobile ☐ Non automobile

4. Are you entitled to Medicare based on:

☐ Age ☐ Disability ☐ End Stage Renal Disease

5. Are you currently employed?

☐ No ☐ Yes

6. Is your spouse currently employed?

☐ No ☐ Yes

7. Do you have health insurance sponsored through your own or spouse's employer?

☐ No ☐ Yes

8. Does the employer that sponsors your insurance plan employ 20 or more employees?

☐ No ☐ Yes

9. Are you currently a patient in a skilled nursing facility such as a nursing home?

☐ No ☐ Yes

I confirm the above information is correct.

Patient Signature: _____ Date: _____

Patient Name (print): _____

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CONSENT TO TREAT & OFFICE POLICIES

CHIROPRACTIC & PRIMARY CARE 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.

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 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 I have discussed non-surgical Chiropractic care and physiological therapeutics and that my provider will discuss any significant risks with me before initiating a treatment or procedure. 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.

MEDICAL RECORDS RELEASE AND STORAGE 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. I understand that my records and imaging reports may be released for professional consultations to other health providers as necessary. Gabbert Medical routinely sends many imaging reports and related health care information to Diagnostic Imaging 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 imaging reports 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 imaging reports for these purposes. I understand that all my records will be kept confidential and will not be released without my written consent.

HEALTH CARE DIRECTIVES

The care of the dying patient is provided to optimize the comfort and dignity of the patient by:

A. Treating primary and secondary symptoms that respond to treatment as desired by the patient and effectively managing pain.
B. Acknowledging the psychosocial and spiritual concerns of the patient.

C. Promoting the right of the patient to make decisions involving his/her health care in collaboration with the provider.

The clinic will maintain documentation in the record if a directive is identified by the patient. The provision of care is not conditioned on the existence of a directive. The clinic will keep the most recent directive in the patient's record. The directives can be changed at any time while the person is competent to do so, and the file will be updated. The clinic and clinic staff are not able to witness, nor facilitate in, the preparation of a living will, advanced directive, power of attorney designation, or other healthcare directive to the physician.

NONDISCRIMINATION POLICY

It is the policy of the clinic to provide services to all persons without regard to race, color, national origin, disability, age, sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)), or religion. The same requirements are applied to all, and there is no distinction in eligibility for, or in the manner of providing services.

The clinic:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (magnifying glasses, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
- If you need these services, contact our 1557 Coordinator: Brian Gabbert, Clinic Director, info@GabbertMedical.com, 928-472-2225.

If patients believe that the clinic has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, they can file a grievance with the Administrator. The patient can file a grievance in person or by mail, fax, or email. If the patient needs help filing a grievance, the Administrator is available to help them.

Patients can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

PATIENT RIGHTS AND RESPONSIBILITIES

You have the responsibility to:

1. Treat staff with consideration, respect and dignity.
2. Understand that your life-style does affect your health.
3. Take an active part in your health care.
4. Follow the agreed upon treatment plan. If you choose or are unable to follow the treatment plan, it is your responsibility to inform the medical provider.
5. Observe facility rules and regulations that are for safety and consideration of all patients and staff.

6. Provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications, advance directives (living wills or durable power of attorney), and other matters relating to your healthcare.
7. Report whether you understand a contemplated course of action and what is expected of you.

You have the right to:

1. Be treated with consideration, respect and dignity.
2. Have the confidentiality of your medical information protected, to have privacy act regulations enforced, and to have these areas of confidentiality explained to you in a language you understand.
3. Have privacy during case discussion, counseling and treatment.
4. Personally review your medical records in the presence of a healthcare professional.
5. Know the name and qualifications of staff providing your care.
6. Know your diagnosis, health problems, test results, the potential advantages and risks of treatment or procedures in language you understand.
7. Expect that all services, treatment and counseling techniques will take place with your informed consent.
8. Participate in referral planning.
9. Refuse to participate in research or experimental treatment.
10. Have another individual present in the exam room with you. If you so desire.
11. File a complaint with the administrator. In the event that your complaint remains unresolved with Gabbert Medical, you may file a complaint with our Accreditor, The Compliance Team, Inc. via their website (https://portal.thecomplianceteam.org/complaint_form.aspx) or via phone 1-215-978-9781.

PATIENT COMPLAINTS

Issues that are not resolved on the spot by staff present are grievances. All issues from patients that call or write to the clinic after services have been rendered are considered grievances because the issues were not resolved during the patient's visit. The administrator will communicate to the person filing the complaint/ grievance within seven (7) days a projected time of response and/or resolution. This response will be no longer than thirty (30) days from the time the complaint is received by the administrator. The administrator will communicate the response/resolution of the complaint/grievance, as appropriate, (in written form when requested or advisable) to the person filing the complaint. Presentation of a complaint/grievance will not in itself serve to compromise the patient's future access to care. All patient complaints/grievance will be kept on file for seven (7) years. In the event that a patient complaint remains unresolved, the patient may file a complaint with their Accreditor, The Compliance Team, Inc. via their website (https:// portal.thecomplianceteam.org/complaint_form.aspx) or via phone 1-215-978-9781. Patients may also contact the Outpatient Treatment Center governing authority to file a complaint at Arizona Department of Health Services via their website https://app3.azdhs.gov/PROD-AZHSComplaint-UI or via phone 602-364-2536.

NOTICE OF PRIVACY PRACTICES & 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 Chief of Staff, Dr. Brian Gabbert who serves as the Privacy Officer. By signing below, I acknowledge that I have been provided with a copy of the ***Notice of Privacy Practices*** for Gabbert Medical (PP-09- 23-13) and is 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:_____

Patient Signature:_____

Relationship to the Patient if under 18yrs:_____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

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

OFFICE POLICIES

OFFICE HOURS
Our office is open Monday through Thursday from 9:00 am to 6:00 pm. Patients are not scheduled from 1:00 pm through 2:30 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 special circumstances 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. A fee of $40 may be assessed for no-show visits if not communicated with our staff in advance and if the office manager deems it appropriate.

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: _____

Patient Signature: _____

Relationship to the Patient if under 18yrs:_____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

HIPAA NOTICE AND PATIENT CONSENT FOR USE, DISCLOSURE & REQUEST/ RELEASE OF PROTECTED HEALTH INFORMATION

Gabbert Medical is committed to protecting the privacy and security of your Protected Health Information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and applicable state laws. This notice explains how your health information may be used, disclosed, and protected and obtains your consent for the release of information, if applicable.

Use & Disclosure of Protected Health Information

- Treatment - Coordinating care among other healthcare providers, pharmacies, or other applicable entities.
- Payment - Billing my insurance company or other responsible parties.
- Healthcare Operations - Quality improvement, compliance audits, and administrative functions.

PHI may also be disclosed as required by law or in cases of medical emergencies, threats to safety, public health concerns, or if required by a court of law. Any other use or disclosure of my health information requires my written authorization, which I may revoke at any time.

Patient Rights

I understand I have the right to:

- Request restrictions on how my PHI is used or disclosed.
- Receive confidential communications about my healthcare.
- Inspect and obtain a copy of my medical records.
- Request corrections to my health information.
- File a complaint if I believe my privacy rights have been violated.

Authorization for Release of Information (ROI)

I authorize Gabbert Medical to obtain or disclose my PHI to the following individuals or entities upon my request. I understand that this authorization applies only to the person(s) or entity(ies) listed below and that I may revoke or modify this authorization at any time. **Please complete this section of the form to encompass any person(s) or entity(ies) that may communicate with Gabbert Medical on your behalf, as we will be unable to communicate with any person(s) or entity(ies) without your explicit permission, under HIPAA privacy rules**. This form may be filled out and submitted again if additional recipient authorizations are desired.

Authorized Person(s) or Entity(ies)	Relation to Patient	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Scope of Information to be Released (Check all that apply):

__ Appointment details (dates/times)	__ Billing & payment information	__ Other (specify):
__ Treatment plans & progress	__ Medication history	_____
__ Lab Results	__ Full medical record	_____

I understand that information shared with authorized individuals may no longer be protected under HIPAA once disclosed. I also understand that Gabbert Medical is not responsible for how authorized individuals use or share my information.

Acknowledgement & Consent

By signing below, I acknowledge that I have read and understand this HIPAA statement. I consent to the use and disclosure of my PHI as outlined above. I understand that this consent remains in effect unless revoked in writing. This consent will remain valid for twelve (12) months from the date of my signature below.

Patient Print Name: _____ Date of Birth: _____
Patient Signature: _____ Today's Date: _____
Relationship to the Patient:_____

SEND RECORDS TO: GABBERT MEDICAL
(F) 928-468-0002
(P) 928-472-2225
info@GabbertMedical.com
120 E. Main St. Ste. B Payson, AZ 85541