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, Asian, Unknown, Refuse to Report
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: _____

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

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

Patient Financial Responsibility Agreement

This Agreement ("Agreement") is entered into by and between_____, hereinafter referred to as "Patient," and [Provider Name], hereinafter referred to as the "Provider," on _____.

1. Fee-for-Service Acknowledgment

The Patient acknowledges that the Provider operates as a fee-for-service healthcare provider, and Medicare does not cover services rendered by non-participating providers.

2. Non-Participation in Medicare

The Patient understands and agrees that the Provider is not a participating provider with Medicare. As a result, Medicare will not reimburse the Patient for any services provided by the Provider.

3. Patient Financial Responsibility

The Patient acknowledges and accepts full responsibility for all fees associated with the services provided by the Provider. This includes, but is not limited to, consultation fees, diagnostic tests, and any other services rendered by the Provider.

4. Payment at the Time of Service

The Patient agrees to make full payment for all services at the time of each visit. The Provider does not submit claims to Medicare on behalf of the Patient, and the Patient is responsible for settling all fees directly with the Provider.

5. Documentation of Non-Coverage

The Patient acknowledges receipt of information regarding the non-participation of the Provider in Medicare and understands the implications of Medicare non-coverage for the services provided.

6. Medicare Waiver

The Patient agrees to waive any right to submit claims to Medicare for reimbursement for services received from the Provider.

7. Governing Law

This Agreement shall be governed by and construed in accordance with the laws of [State], without regard to its conflict of laws principles.

IN WITNESS WHEREOF, the Patient and Provider have executed this Agreement as of the date first above written.

Print Name _____

Signature _____

Date _____

NO-SHOW / CANCELLATION POLICY

Appointment and Cancellation Policy

We understand the importance of timely access to healthcare and are committed to providing you with the best possible care. To ensure appointment availability for all patients, we have implemented the following policy:

Payment Information

Effective immediately, we may request a payment method on file. Please be assured that no charges will be incurred unless you miss an appointment, cancel within 48 hours of your scheduled appointment, or have completed services.

Appointment Scheduling and Cancellations

- **Arriving on Time:** Please arrive on time for your scheduled appointment with new patient forms completed.
- **Cancellations:** If you are unable to keep your appointment, please provide at least 48 hours' notice.
- **Late Arrivals:** Depending on the provider's schedule, you may be asked to reschedule if you arrive more than 10 minutes late. Please note that if you come in late, the remaining time of your appointment will remain as scheduled and no extra time will be given. Please call our office as soon as possible if you are running late.

Missed Appointment Fees

- **First missed appointment:**
    - New patient: $250
    - Established patient: Half of the visit fee
- **Second missed appointment:** Full visit fee
- Patients who miss more than two appointments may be required to prepay for future appointments. Alternatively, they may call the day of the desired appointment to check for available openings. Patients with a card on file will be subject to the fees outlined above and scheduling restrictions will not apply.

We appreciate your understanding and cooperation in adhering to this policy.

Patient initials: _____ 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.