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: _________________

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

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

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.