## 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:_____