Jake Gurland, M.D.
523 Broadway
Bayonne, NJ 07002

PATIENT INFORMATION FORM

Patient Name: **SS#** **Date of Birth:**

Address: **City:** **State:** **Zip:**

Phone Number: **Email Address:**

Who Referred you to us? **Referring Physician:**

Injury: **Date of Accident:** **Pharmacy:**

INSURANCE INFORMATION (Please provide these to the front desk to be scanned into your chart)

Primary Insurance Carrier: **ID#**

Phone # on back of card: **Group#**

Secondary Insurance Carrier: **ID#**

Phone # on back of card: **Group#**

Tertiary Insurance Carrier: **ID#**

Phone# on back of card: **Group#**

Past Medical History:

Family Medical History:

Medical Issues:

Surgeries:

Current Medications (please include any vitamins or over the counter medications):

See attached medication form Feel free to bring your bottles with you**

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PATIENT AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name: **DOB:**

Jake Gurland, MD reserves the right to obtain the following: Check the appropriate boxes and include other information where indicated.

__ Chart Notes __ Op Reports __ Discharge Summary __Entire

__ Radiology Reports __ Diagnostic Reports __ Lab Reports

Other:

_____

This authorization will remain in effect for the duration of treatment. I have read and understand the terms of this authorization. I hereby knowingly and voluntarily authorize Jake Gurland, MD to obtain my information in the manner described above.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of authorized Legal Guardian, Health Care Agent **Date**

Or authorized Personal Representative

_____

Relationship

Jake Gurland, M.D.
523 Broadway
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HIPAA AUTHORIZATION FOR SHARING INFORMATION

I hereby authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individuals.

Name: _____ Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultations, billing or claims payment or other purposes as I may direct.

_____ _____

Signature of Patient Date

Patient Consent for My Provider to
File an Appeal on my Behalf with my Health Insurance Plan

Provider Name:	**Provider Plan ID Number:**
Provider Address:	
Description of services that may be appealed:	**Date(s) services were provided:**

I agree to allow this health care provider to file an appeal on my behalf with the following health plan if there is a question about coverage for the services listed below.

I understand that:

1. If I consent, I will not be able to file my own appeal concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing.
2. I have a right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time.
3. This consent shall be automatically rescinded if my health care provider does not file an appeal, or stops appealing my case.

I have read this consent or have had it read to me, and it has been explained to my satisfaction.

I understand the information in the consent form, and grant my consent to this provider to file an appeal on my behalf.

Print Patient Name: ✕ ✕	**Patient Date of Birth:**	**Health Insurance Company**:
Patient Address:	**Patient Insurance ID Number:**	
Patient Signature: ✕	**Signature Date:** ✕	

The above named enrollee is unable to sign this consent form because of the following reasons and I consent for the above named enrollee:

Print Representative Name:	**Relationship to the Patient:**
Representative Signature:	**Signature Date**:

Print Witness Name:	**Witness Signature:**	**Signature Date:**

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Patient Consent / Authorization

Consent for Treatment:
I voluntarily consent to the rendering of care, including treatment of vaccine administration, blood draws and diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physicians.

Assignment of Benefits:
I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. In addition, I agree to allow Jake Gurland, MD to file an appeal on my behalf with my insurance company for any denied claims for services rendered by the provider. If in the event our claim for services is denied after appeal, a discounted balance will be the responsibility of the patient. Medicare patients are required to sign an ABN for in house testing, this is to advise of non covered services.

Release of Information:
The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s), to the patient, to the family member or employer of the patient for all or part of the physician's charges, including but not limited to, insurance companies, worker's compensation carriers, no fault/pip carriers, disability, welfare funds or the patient's employer.

Medicare Patient Certification - Patient's Certification Authorization to Release Information and Payment Request:
I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services. I understand that I am responsible for my health insurance deductible and coinsurance.

Privacy Practices Notification:
By my signature on this form I acknowledge that I have been provided with Jake Gurland, MD's Privacy Practices either via email, patient portal or written letter.

Prescription History Authorization: I authorize Jake Gurland, MD to view my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

Office Policy Updates: (as of 8.1.22)

- All controlled medications will require an office visit every 30 days, no exceptions. Please set up all visits one week prior to your next refill to avoid any delays.
- For Cancellations - Please cancel within 24 hours of your appointment time, if not a $25.00 charge will be placed on the account.
- Co-pays are to be paid prior to your telehealth visit. A phone call and text (with link to pay) will be made to you prior to your appointment. If you are unreachable, your appointment will be considered a No Call No Show after 15 minutes and you will be billed the $25 charge.
- When running late for your appointment time, please reach out to the office and kindly let us know, as we allow a 15 minute grace for all appointments. After the 15 minutes you will be considered a No Call No Show and be charged the $25.00 fee.

Should you have any questions, always feel free to contact the office to discuss. Thank you and we are looking forward to seeing you on your visit.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

Today's Date _____

Patient's Name _____ **Patient's Signature** _____

Witness Name Leslie Wiemmer **Witness Signature** Leslie Wiemmer

Witness Relationship - Jake Gurland, MD Employee