DR. DANTE GABRIEL, MD, SC
Dante Gabriel, MD, FAAP
Faye Montes, MD, FAAP
Alma Guzman, MD, FAAP
Marson Tenoso, MD, FAAP

Agreement to comply with office Policies

The policies and rules set forth on this form are for the benefit of our office/ staff as well as our patients. Please be advised that failure to comply with these policies may result in violation of our practice policies and rules which may lead to ending our patient-provider relationship.

Appointment policies and "No-Show" or "Late-Cancel" fees are as follows:
Appointments made the same day for sick patients must be kept, if you are unable to keep your appointment a late cancellation fee of $30.00 will be assessed to your account.

Well-Child appointments are asked to be made in advance; as much as we strive to accommodate all of our patients as often as possible there are times we may not be able to get you in right away, to avoid this we ask that you make your appointments in a timely manner to better suit your needs. A 24-hour notice for cancellations is required; there is a $30.00 late cancellation fee or a $55.00 No-show fee for broken appointments.

Disruptive/ abusive behavior in the office will not be tolerated and may lead to the immediate termination of patient-provider relationship. Disruptive and abusive behaviors include but are not limited to the following:

1. Profane or disrespectful language.
2. Demeaning behavior (ex: referring to our staff as "stupid" or any derogatory names)
3. Sexual comments.
4. Throwing things or charts.
5. Outbursts of anger.
6. Criticizing office staff in front of other patients.
7. Negative comments about staff or physicians.
8. Boundary violations with staff or patients.
9. Unethical or dishonest behavior.
10. Verbal or physically threatening behavior.

By signing I acknowledge and agree to comply with the office policies and am aware of possible consequences if this agreement is broken.

Parent/Guardian Signature: _____ Date:_____

Patient Name:_____ DOB:_____

Patient Name: _____ DOB: _____

15 Tower Ct., Suite 150, Gurnee IL, 60030
Tel: 847-623-4464 Fax: 847-623-9984

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I give my consent to the doctor's named above, to use or disclose all information contained in my child's medical record for the purpose of carrying out treatment, payment and/or continuity of my child's healthcare.

I understand that I may revoke this consent at any time by giving written notice to the office upon my desire.
I acknowledge receipt of the Physician's Notice of Privacy Practices.
Parent/ Guardian signature: _____ Date: _____
For security purposes we need the social security numbers and relationship to patient along with the names of any person/s who have authorization to obtain this child's private medical records or health information:
Name: _____ SS#: _____ Relation: _____
Name: _____ SS#: _____ Relation: _____

Please note that our office charges the following fees:

Returned check = $35.00 Copies of Immunizations = $2.00
No Show sick visit = $35.00 Sports/School/Camp Physical forms = $15.00
No Show routine exam = $55.00 FMLA Papers/ forms = $25.00
Misc letters from this office $5.00 Social Sec & Immigration forms = $5.00
Late Cancellations = $30.00 Medical records release = $15.00

I acknowledge the fees listed above and agree to pay any fees I may be charged for missed appointments or any forms I may request from the office. I agree to pay any and all service fees that my insurance denies to pay for whatever reason. I will pay for any and all charges upon written or verbal notice.
Be advised if there are any sick symptoms during a well-child exam your insurance may charge a copay, which is your responsibility to pay at the time of services.
Parent/Guardian signature: _____ _ Date: _____

Please list the name and date of birth of all Patients this form pertains to:

_____ _____
_____ _____
_____ _____

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