HAROLD GOODMAN, D.O.
8609 SECOND AVENUE, SUITE 405B
SILVER SPRING, MARYLAND 20910

(301) 565-2494
(301) 565-2495

PATIENT INFORMATION

Name _____birth date_____
Address (street)_____apt#_____
(town, state, zip)_____
Telephone: home_____work_____
cell phone_____e-mail_____
Guardian (if a minor)_____relationship_____
Address (if different)_____
_____telephone_____

Employer_____ Occupation_____
Spouse (full name)_____
Employer_____daytime telephone _____
Nearest relative not living with you_____
Telephone_____Address_____

Name of health insurance company_____
Is this a motor vehicle accident?_____ Name of car insurance_____
Is this a legal case? _____ Name of lawyer_____
lawyer's telephone_____
Is this a workers' compensation case?_____

I, _____ understand that payment for services provided by this office is solely my responsibility, regardless of any insurance coverage I may have. I understand that Dr. Goodman does not participate with any insurance, including Medicare, and responsibility for filing any claims, except Workers' Compensation, is mine. I authorize the release of any information relating to any claim for benefits, in order to process any claim for benefits. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

Date_____
Signature (by patient or responsible party_____

Name_____Age_____Referred by_____
Height_____Weight_____

MEDICAL HISTORY

Check any of the following conditions you have had:

__Arthritis	__Diabetes	__Skin condition
__Heart disease	__Tuberculosis	__Headaches
__Cancer	__Respiratory problems	__Genital/urinary problems
__Recent weight gain/loss	__Gout	__Bleeding ulcers
__High blood pressure	__Stomach disorders	__Glandular/thyroid disorders

Are there any other medical problems that we should be aware of?_____
_____

Any allergies? (Hay fever, penicillin, drugs, etc.)_____
_____

List all medications you are currently taking:

Name	Dose	Taking Since	Effect

List all scars on your body._____
_____

List all operations and illnesses which required hospitalization.
_____Year_____
_____Year_____
_____Year_____

List any injuries (severe sprains, fractures, dislocations) or other bone or joint problems.
_____ Year_____
_____ Year_____
_____ Year_____

If female, number of pregnancies ____ number of children_____ last period_____
Are you pregnant now?_____

Other Healthcare Providers
Name_____Specialty_____
_____
_____

Name_____

SOCIAL HISTORY

Single__ Married__ Divorced___ Widowed___

How would you describe yourself? Normal___ Nervous___ Depressed___ Tense___

Cry easily___ Quick temper___Outgoing___ Shy____ Reserved___

Activity at work: Sitting____ Moderately Active___ Heavy Labor____ Computer___

Do you drink alcohol? ___ How often?_____

Do you smoke? ____ How much?_____

Do you exercise, play sports?____Type_____ Frequency_____

_____

Are you right handed or left handed? If right handed, do you do anything with your left?_____

_____

CURRENT PROBLEM

Mark the area on this picture where you feel the present problem(s), using the most appropriate symbols. Use no other symbols except those indicated.

Numbness

_____

_____

Pins & Needles

- - - - - - - -

- - - - - - - -

Burning Pain

O O O O

O O O O

Sharp Stabbing Pain

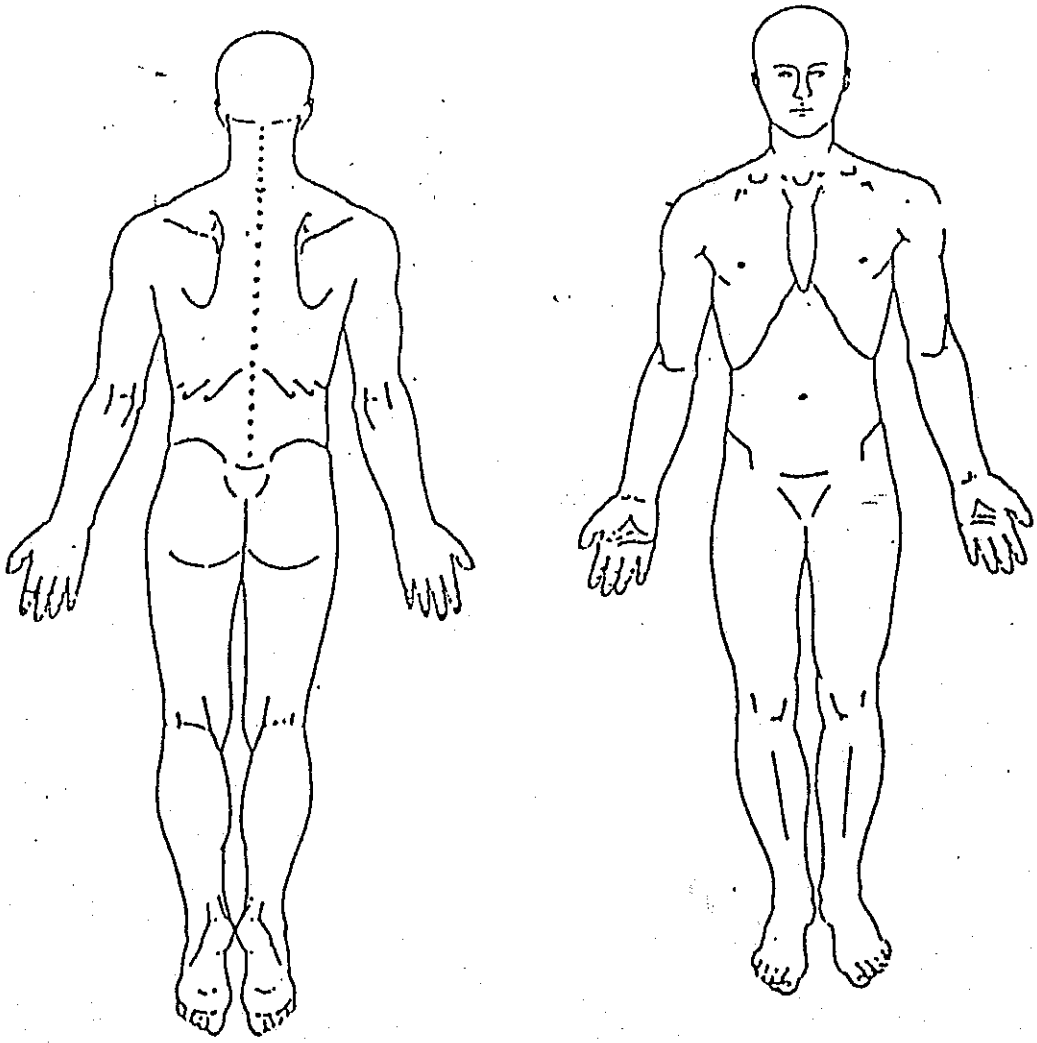
X X X X

X X X X

Aching Pain

A A A A

A A A A



Name_____

Chief complaints in order of importance to you:
_____since_____cause_____
_____
_____

Have you had any of these problems before?_____
_____

How often do you have these symptoms?_____
How long do they last?_____
What helps?_____
What makes it worse?_____
Any change in bladder or bowel function?_____
If female, is it worse with periods?_____
Are you limited in any activities? Which?_____
_____

Have you received treatment for this problem before?
Type of treatment_____When?_____Helpful?_____
_____
_____

Have you missed work for this complaint?_____How long?_____
Anything else you'd like to
add?_____
_____
_____

STATEMENT OF FINANCIAL POLICY

Payment for your medical treatment at this office is the responsibility of each patient. Health insurance is considered a method of reimbursing the patient for fees paid for medical treatment. Our bills provide you with the information you need for maximum reimbursement. Payment is expected at the time services are rendered unless special arrangements have been already made with the office. We accept cash, checks or Visa or Mastercard. If you were injured on the job and are covered by Workers' compensation we will bill your carrier for payment. You will be responsible for providing billing and contact information to us before you come in for your visit and if your carrier denies the claim, you will be responsible for the outstanding balance. Reports will be furnished on request. This request must be in writing and must specify to whom the report should go. We require a fee for preparation of medical reports.

I have read the above statement of financial policy and understand the information contained in it.

Signature_____Date_____

HAROLD GOODMAN, D.O.
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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____. have received a copy of Harold Goodman, D.O.'s Notice of Privacy Practices.

_____ _____

Signature of Patient Date

HAROLD GOODMAN, D.O. LLC
8609 SECOND AVENUE, SUITE 405B
SILVER SPRING, MARYLAND 20910

(301) 565-2494
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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE READ IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician, pharmacist, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present,

then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed forces personnel under certain circumstances. We may disclose to authorized federal officials health information to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the beginning of this Notice.We will charge you a reasonable cost-based fee for expenses such as copies and staff time.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last six years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing and must specify the alternative means or location.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. We must provide you a letter of denial explaining our reasons for denial.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, you may complain to us using the contact information listed at the beginning of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Service.