

## 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:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Skin condition              |
| <input type="checkbox"/> Heart disease           | <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Headaches                   |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Genital/urinary problems    |
| <input type="checkbox"/> Recent weight gain/loss | <input type="checkbox"/> Gout                 | <input type="checkbox"/> Bleeding ulcers             |
| <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Stomach disorders    | <input type="checkbox"/> 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:

<u>Name</u>	<u>Dose</u>	<u>Taking Since</u>	<u>Effect</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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.

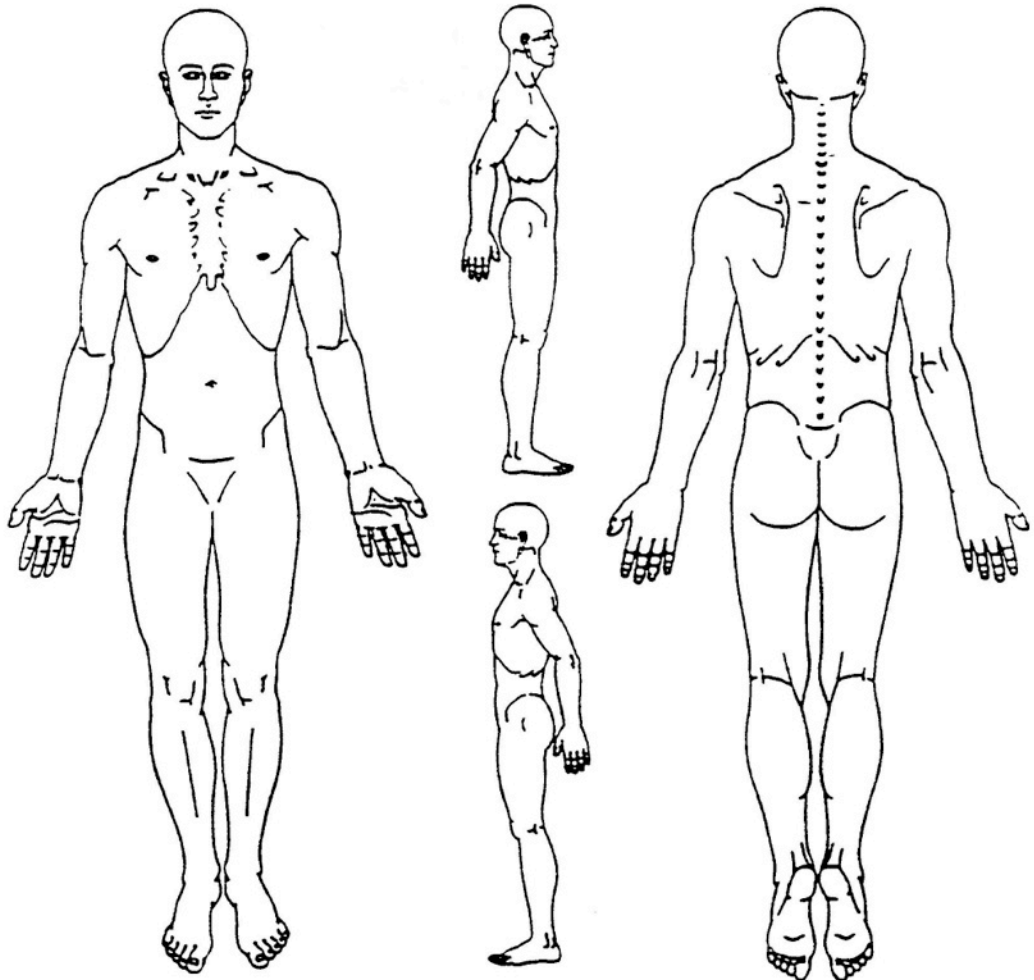
Numbness  
\_\_\_\_\_  
\_\_\_\_\_

Pins & Needles  
-----  
-----

Burning Pain  
OOOO  
OOOO

Sharp, Stabbing Pain  
XXXX  
XXXX

Aching Pain  
AAAA  
AAAA



HAROLD GOODMAN, D.O.

8609 SECOND AVENUE | SUITE 405B | SILVER SPRING, MD 20910 | 301-565-2494

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 ACKNOWLEDGMENT FORM**

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

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

## 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 REVIEW 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 or with payment for 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 required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official 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 email, voicemail 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 6 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 additional 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 or to have us communicate with you by alternative means or at alternative locations, 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 Services.