HAROLD GOODMAN, D.O. | 8609 SECOND AVENUE | SUITE 405B | SILVER SPRING, MD 20910 | 301-565-2494

Patient Information

Name _____ Age _____ Date of birth _____

Referred by_____ Height _____ Weight _____

Address (street) _____ Apt. # _____

(town, state, zip) _____

Telephone: Mobile _____ Work _____

Landline _____ Email _____

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 _____

Is this a worker's compensation case? _____ Lawyer's telephone _____

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?_____

_____

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MEDICAL HISTORY

Check any of the following conditions you have had:

- ❒ Arthritis
- ❒ Heart disease
- ❒ Cancer
- ❒ Recent weight gain/loss
- ❒ High blood pressure
- ❒ Diabetes
- ❒ Tuberculosis
- ❒ Respiratory problems
- ❒ Gout
- ❒ Stomach disorders
- ❒ Skin condition
- ❒ Headaches
- ❒ Genital/urinary problems
- ❒ Bleeding ulcers
- ❒ Glandular/thyroid disorder

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 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 applicable: # Pregnancies ___ # Children ___ Last period _____ Currently pregnant? _____

Other Healthcare Providers:

Name _____ Specialty _____

Name _____ Specialty _____

Name _____ Specialty _____

Name _____ Specialty _____

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Name _____ Birth date _____

CURRENT PROBLEM

Chief complaints in order of importance to you:

_____ Since _____ Cause _____
_____ Since _____ Cause _____
_____ 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 you'd like to add? _____
_____

Please print this page and mark with a pen or pencil the area on the picture where you feel the present problem(s), using the most appropriate symbols. Use no other symbols except those indicated.

Numbness
_____
_____

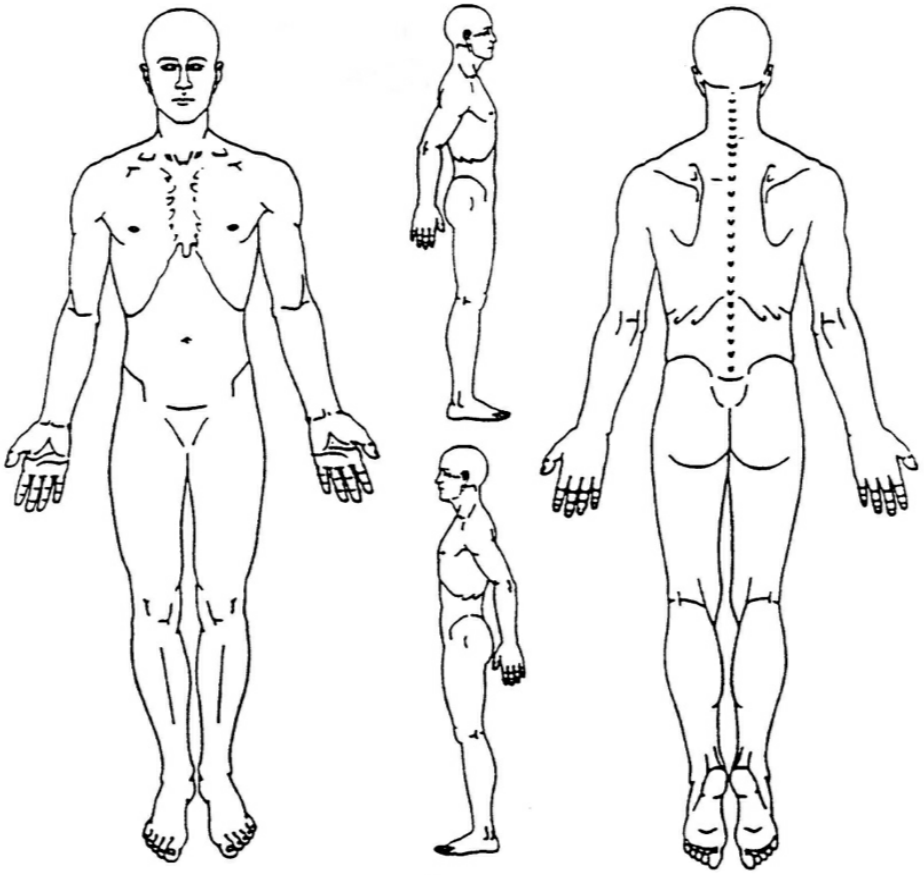
Sharp, Stabbing Pain
XXXX
XXXX

Pins & Needles

Aching Pain
AAAA
AAAA

Burning Pain
OOOO
OOOO

You can send along a scan or a photo or just bring this page with you.



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 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, _____, 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)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

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

_____

Name

_____ _____

Date Signature (by patient or responsible party)

If signed by personal representative, please describe relationship to patient and authority to act on patients' behalf:

_____

FOR OFFICE USE ONLY

If acknowledgment not obtained, document reason:

☐ Emergency situation ☐ Patient refused to sign ☐ Other: _____

Staff Initials: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Commitment to Your Privacy
Harold Goodman, D.O., LLC is committed to protecting the privacy of health information. We are required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of Privacy Practices (Notice) of our legal duties and privacy practices regarding your PHI, and follow the terms of the Notice currently in effect.

This Notice tells you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your health information.

The privacy practices described in this Notice will be followed by all members of the workforce at Harold Goodman, D.O., LLC, including health care professionals, employees, trainees, students, and volunteers. Additionally, third parties ("business associates") that provide services on our behalf will be required to comply with all applicable provisions.

How We May Use and Disclose Health Information About You
The following sections describe different ways we may use and disclose your health information. We abide by all applicable laws related to the protection of this information. Not every use or disclosure is listed. All of the ways we are permitted to use and disclose health information, however, will fall within one of the following categories:

Treatment. We may use and disclose your health information to provide, coordinate, or manage your healthcare and related services. This includes consultation with other healthcare providers regarding your treatment and referral to another provider. For example, your primary care physician may share your health information with a specialist to coordinate your care.

Payment. We may use and disclose your health information to obtain payment for services we provide. This includes billing activities, claims management, and collection activities. For example, we may send claims to your health insurance company containing certain health information to obtain payment for services we provided.

Healthcare Operations. We may use and disclose your health information for our healthcare operations, which include internal administration and planning and various activities that improve the quality and cost-effectiveness of care. For example, we may use health information to evaluate the performance of our staff, assess the quality of care, or conduct training programs.

Other Uses and Disclosures We May Make Without Your Authorization:
As Required by Law. We may disclose health information when required by federal, state, or local law.

- **Law Enforcement**. We may disclose health information to law enforcement officials for law enforcement purposes as permitted by law.
- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose health information to coroners, medical examiners, and funeral directors to carry out their duties.
- **Organ and Tissue Donation.** We may disclose health information to organizations involved in the procurement, banking, or transplantation of organs, eyes, or tissue.
- **Research**. We may use or disclose health information for research purposes when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your information.
- **To Avert a Serious Threat to Health or Safety.** We may use or disclose health information when necessary to prevent a serious threat to the health or safety of you, another person, or the public.
- **Specialized Government Functions.** We may disclose health information for military, national security, protective services, or correctional institution purposes as authorized by law.
- **Workers' Compensation**. We may disclose health information as authorized by workers' compensation laws, unless you say no, to anyone involved in your care or payment for your care, such as a friend, family member, or any individual you identify.

Substance Abuse Treatment. We are required to protect the privacy and security of your substance use disorder patient records in accordance with 42 U.S.C. § 290dd–2 and 42 C.F.R. Part 2, the Confidentiality of Substance Use Disorder Patient Records ("Part 2"), in addition to HIPAA and applicable state law. In a civil, criminal, administrative, or legislative proceeding against an individual, we will not use or share information about your SUD treatment records unless a court order requires us to do so (after notice and an opportunity to be heard is provided to you, as provided in 42 CFR part 2) or you give us your written permission You may report suspected violations to the U.S. Attorney for the judicial district in which the violation occurs. Contact information for the U.S. Attorney office where we operate is below:

U.S. Attorney for the District of Maryland: **Main office**, 36 S. Charles Street 4th Fl., Baltimore, MD 21201; Phone: (410) 209-4800
Southern Division, 6406 Ivy Lane Ste 800, Greenbelt, MD 20770; Phone: (301) 344-4433

Suspected violations by an opioid treatment program may be reported to the Substance Use and Mental Health Services Administration (SAMHSA), Opioid Treatment Program Compliance Office by phone at 204-276-2700 or online at OTP-extranet@opiod.samhsa.gov.

Uses and Disclosures That Require Your Written Authorization.
We will obtain your written authorization before using or disclosing your health information for purposes other than those described above. Specifically, we will obtain your authorization before using or disclosing:

- Psychotherapy notes (with limited exceptions)
- Health information for marketing purposes
- Health information in a manner that constitutes a sale of PHI

Additionally, with certain limited exceptions, we are not allowed to sell or receive anything of value in exchange for your health information without your written authorization. If you provide us with authorization to use or disclose your health information about you, you may revoke your authorization, in writing, at any time.

However, uses and disclosures made before the revocation of your authorization are not affected by your action and we cannot take back any disclosures we may have already made with your authorization or that may have been made on reliance of your authorization.

Use of unsecure electronic communications.
If you choose to communicate with us via unsecure electronic communications, such as regular email or text message, we may respond to you in the same manner in which the communication was received and to the same email address or account from which you sent your original communication.

In addition, if you provide your email address or cell phone number to a health care provider, we may send you emails or text messages related to appointment reminders, surveys, or other general informational communications. For your convenience, these messages may be sent unencrypted.

Before using or agreeing to use of any unsecure electronic communication to communicate with us, note that there are certain risks, such as interception by others, misaddressed/misdirected messages, shared accounts, messages forwarded to others, or messages stored on unsecured, portable electronic devices.

By choosing to correspond with us via unsecure electronic communication, you are acknowledging and agreeing to accept these risks. Additionally, you should understand that the use of email or other electronic communications is not intended to be a substitute for professional medical advice, diagnosis, or treatment.

Your Rights Regarding Your Health Information.
You have the following rights regarding the health information we maintain about you:

Right to Inspect and Copy.
You have the right to inspect and obtain a copy of your health information that may be used to make decisions about your care, including medical and billing records. To inspect or copy your health information, submit a written request to our Privacy Officer. We may charge a reasonable fee for copying and mailing costs.

Right to Amend.
If you believe that information in your record is incorrect or incomplete, you may request that we amend it. To request an amendment, submit a written request to our Privacy Officer that includes the reason for your request. We may deny your request in certain circumstances, and if we do, we will provide you with a written explanation.

Right to an Accounting of Disclosures.
You have the right to receive a list of certain disclosures we have made of your health information. To request an accounting, submit a written request to our Privacy Officer specifying the time period for which you want the accounting (not to exceed six years). The first accounting in a 12-month period will be provided free of charge; subsequent requests may incur a reasonable fee.

Right to Request Restrictions.
You have the right to request restrictions on how we use or disclose your health information for treatment, payment, or healthcare operations, or to restrict disclosures to family members or others involved in your care. We are not required to agree to your request except in one situation: if you pay for a service or item out of pocket in full, you can ask us not to share information about that service or item with your health insurer for payment or healthcare operations purposes, and we will honor that request.

Right to Request Confidential Communications.
You have the right to request that we communicate with you about health matters in a certain way or at a certain location. To request confidential communications, submit a written request to our Privacy Officer specifying how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice.
You have the right to a paper copy of this Notice of Privacy Practices at any time. You may also obtain a copy of this Notice by visiting https://drharoldgoodman.com/privacy or by contacting our Privacy Officer at the address provided at the end of this Notice.

Right to Be Notified of a Breach.
You have the right to be notified in the event that we discover a breach of your unsecured health information. Right to a Paper Copy of this Notice**.**

Changes to the Terms of This Notice.
We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, in our facility, and on our web site.

Complaints.
If you have any questions about this Notice or our privacy practices, or if you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at the address and phone number below. You will not be retaliated against for filing a complaint. If you wish to exercise your HIPAA rights or make a complaint, please contact our Privacy Officer.

Contact Information

Privacy Officer: Harold Goodman, D.O.
Address: 8609 2nd Ave #405B, Silver Spring, MD 20910
Phone: 301-565-2494
Email: admin@drharoldgoodman.com

To File a Complaint with HHS:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201
Phone: 1-877-696-6775
Website: www.hhs.gov/ocr/privacy/hipaa/complaint