About your appointment

We welcome you to the allergy office of Dr. Paul M. Goldberg. Attached you will find the directions to the office as well as the new patient form.

Please complete the new patient form and bring it with you to your appointment along with your insurance card and appropriate referral if one is required with your insurance.

If the appointment is for a child, please bring only the child being seen.
If you must bring a child along who is not the patient, please bring someone who can stay in the waiting area while you are with the doctor.

Copay is due at the time of services. Please bring copay in the form of check, money order or cash.

Dr. Goldberg does not double book, therefore promptness is appreciated.
(He tries to begin each patient at the scheduled time)

Our office policy requires 24 hours notice if you must cancel your appointment.

Patient:_____
Day:_____
Date:_____
Time:_____

Chevy Chase office : 5530 Wisconsin Avenue, Suite 1045,
Chevy Chase , MD 20815
301 670-8338

Paul M. Goldberg, D.O. P.C.
Allergy, Asthma and Clinical Immunology
REGISTRATION FORM

Date_____ Referred or learned of us by_____

Patient:

Last Name_____First_____M.I._____

Street Address_____

City_____State_____ZIP_____

Phone# HOME_____WORK_____ext_____CELL_____

e-mail address_____ Social Security # _____

Employer_____ Full Time or Part Time

Employer's address_____

Age _____Date of Birth _____(*required on insurance claims*) Marital Status _____ Sex ___M___F

Student Status: Full Time_____ Part Time_____ N/A_____

Please list one designated representative who we may contact concerning your issues. _____ initial here

Name_____Phone#_____Relationship_____

Please list an emergency contact person who **does not** live with you.

Name_____ phone # home_____work_____

Please list an emergency Name_____& Number_____ of a relative **Not** living with you

INSURANCE INFORMATION Date of Birth of Insured if not the patient_____

Do you have medical insurance? Yes___ No___ If no, payment is due at time of service

If patient is not the insured, whose name is insurance under_____

Relationship to patient: (Spouse, parent, etc)_____

Name of Insured: Last_____First_____ M.I._____

Street address _____

City_____State_____ Zip _____

Phone: Home _____ Work _____ Cell _____

Place of employment (company name) _____ SS# _____

Address of employer _____

Name of Insurance Company _____

Claims mailing address of insurance company _____

_____

Claims phone # for providers to contact insurance _____

Subscriber ID #_____Group #_____ Contract # _____

LIST SECONDARY INSURANCE BELOW (IF APPLICABLE)

Name of secondary insurance company_____

Claims mailing address of the secondary insurance _____

Claims phone # for providers to contact insurance _____

Subscriber ID# _____ group # _____Contract # _____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and / or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims or benefits, for services rendered , without obtaining my signature on each and every claim to be submitted for myself and / or dependents, and that I will be bound by the signature as though the undersigned has personally signed the particular claim. I hereby authorize my insurance company to pay and hereby assign directly to Dr. Paul M. Goldberg all benefits, if any, otherwise payable to me for his services as described on the claim forms. I understand I am financially responsible for all charges incurred. I will be responsible for all expenses necessary to collect any remaining balances overdue. I further acknowledge that any insurance benefits, when received by and paid to Dr. Paul M. Goldberg will be credited to my account, in accordance with the above said assignment.

_____ _____ _____

signature date printed name

Paul M. Goldberg, D.O. P.C.

Allergy, Asthma and Clinical Immunology

New Patient Form

(Please answer pages 1-5 and sign page 6)

Date_____ Name _____AGE_____

Pharmacy : phone #_____ Name and Location_____

If referred, by whom_____ _Who is your primary physician? _____

Please list your main problem(s) for coming here in order of severity, **#1 being the most severe**

___itchy eyes ___cough
___sneezing ___chest tightness
___runny nose ___wheezing
___stuffy nose ___itching of skin
___postnasal drip___food allergy
___ear popping ___insect allergy
___headache ___drug allergy
___other_____

DO NOT WRITE ON THIS SIDE

Please circle the best response (**N=Never, S=Sometimes, A= really bothers me**)

EYES

Do you frequently have:

A) Itchy eyes	N	S	A
B) Excessive tearing, watery eyes	N	S	A
C) Red eyes	N	S	A
D) A gritty sensation in your eyes	N	S	A
E) Mucus in the inner corner of the eyes	N	S	A
F) Puffiness below the eyes, lower lids	N	S	A

NOSE

Do you frequently have:

A) A congested nose	N	S	A
B) A watery nose	N	S	A
C1 A lot of post-nasal drip	N	S	A
C2 A discolored post-nasal drip (Green, Yellow, or Brown)	N	S	A
D) The need to clear your throat	N	S	A
E) An itchy sensation in your nose	N	S	A
F) An itchy throat or upper palate	N	S	A
G) An itchy sensation deep in your ears	N	S	A
H) 3 or more sneezes in a row	N	S	A
I) A loss of sense of smell or taste	N	S	A
J) A cough that lasts a month or more	N	S	A
K) A history of nasal polyps	N	S	A
L) Sinus pain, pressure, or recurrent sinus infections	N	S	A
M) Nasal symptoms coming on like attacks	N	S	A

Patient's name_____

THROAT

DO NOT WRITE ON THIS SIDE

Do you frequently have/feel:

A) Sore throat	N	S	A
B) Worse in the morning	N	S	A
C) Trouble swallowing	N	S	A

EARS

Do you have:

A) Frequent earaches	N	S	A
B) Decreased hearing	N	S	A
C) Ears that pop	N	S	A
D) Recurrent ear infections	N	S	A

LUNGS

Do you frequently suffer from:

A) Attacks of wheezing	N	S	A		
B) Episodes of shortness of breath	N	S	A		
C) Increased production of phlegm	N	S	A		
D) Prolonged bouts of coughing, Especially after exercise or laughing	N	S	A		
E) Tightness in the chest	N	S	A		
F) Sharp pains with each breath	N	S	A		
G) Has a diagnosis of asthma ever been made?				Y	N
H) Have you ever been hospitalized for asthma?				Y	N
I) Have you used any steroids or cortisone drugs?				Y	N
If so, please specify_____					
J) Do you get burning in your stomach?				Y	N
If so, when?_____					

Please check the appropriate space if you experience Wheezing/Coughing . (**Y=Yes, N=No**)

	Y	N		Y	N
daily	__	__	worse in winter	__	__
weekly	__	__	limits activity	__	__
monthly	__	__	daily medication	__	__
few times / year	__	__	only with colds	__	__
certain exposures	__	__	worse at school/work	__	__
certain seasons	__	__	worse in warm weather	__	__
worse at night	__	__	frequent emergency room visits	__	__
with exercise	__	__	hospitalization	__	__
inhalers help	__	__			

Patient's name_____

SKIN Y N *DO NOT WRITE ON THIS SIDE*

Do you have:
A) Skin that itches intensely __ __
B) Patches or blotches which appear and disappear abruptly __ __
C) A history of eczema as a child __ __
D) A history of hives __ __
E) A history of swelling around your eyes lips, or tongue which made it hard to breathe __ __
F) A rash which occurs with certain clothes __ __
G) A rash which occurs with certain foods __ __

Please check the appropriate space if you experience Hives/Welts. **(Y=Yes, N=No)**

	Y	N		Y	N
few times per day	__	__	worse with anxiety	__	__
few times per week	__	__	worse with exercise	__	__
few times per month	__	__	itchy	__	__
few times per year	__	__	mainly face	__	__
all over body	__	__	worse with cold	__	__
raised large	__	__	swelling of body parts	__	__
worse with heat	__	__	fevers	__	__
joint pain	__	__	worse with certain foods	__	__
stomach aches	__	__	medications help	__	__
areas of rubbing	__	__	other blood studies done	__	__

FOOD ALLERGIES

Do you have the following:

A) A food allergy (specify food)_____Y N
_____
B) Specify symptoms produced by these foods _____
_____
_____
C) Symptoms occurring within 1-2 hours of eating the food Y N

INSECTS

Do you have allergic reactions to: (circle which apply)
A) Bees, wasps, hornets, yellow jackets or fire ants. Y N
B) Other insect bite / or unsure(specify) _____
How long has this been a problem? _____

Patient's name_____

When are the symptoms worse? (Check the space)

DO NOT WRITE ON THIS SIDE

Spring___Summer___Fall___Winter___
Morning___Day___Evening___Sleeping___
Outdoors___In house___Damp___Windy___
Dry___Hot___Cold___Exercising___
Emotionally upset___Eating___School___
Work___Car___In Grass___In Basement___
Change of Seasons___Smoke___Around Pets___
Outdoors___Strong Odors___Moldy, damp rooms___
Anything else that makes you worse_____

What has helped?_____
Have you had allergy testing?_____ Did you have positive results?____
Where and when were you tested?_____
Have you been on allergy shots?_____For how long?_____

Days of school or work missed in the past year_____

PAST MEDICAL HISTORY

Please list any other medical problems_____
_____

Please list hospitalizations (why and when)_____
_____

Have you had any emotional problems?_____
Please list all current medications_____
_____
_____
_____
_____

Please list any medication allergies known or suspected_____
_____

Please list all surgeries _____
_____

FAMILY HISTORY:

	Allergies	Asthma	Frequent Coughing	Frequent Infections	Other
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Children	_____	_____	_____	_____	_____

Patient's name_____

ENVIRONMENTAL HISTORY:

Do not write on this side

Does your home contain:

	Y	N		Y	N		Y	N
Cat	_	_	Central A/C	_	_	Townhouse, house	_	_
Dog	_	_	Gas Heat	_	_	Apartment, condo	_	_
Birds	_	_	Electric Heat	_	_	Stuffed animals	_	_
Other pets	_	_	Oil Heat	_	_	Old mattress	_	_
Plants	_	_	Wood stove	_	_	Feather pillows	_	_
Wall to wall rugs	_	_	Kerosene Heat	_	_	Down comforter	_	_
Hardwood Floors	_	_	Air cleaner	_	_	Damp basement	_	_
Do you smoke?	_	_	Humidifier	_	_	Frequent exposure		
If so, how much and how long? _____						To fumes	_	_

SOCIAL HISTORY:

Occupation:_____

Please list any hobbies_____

_____

Who does the patient live with?_____

_____

Alcohol use?_____ How much?_____

DO YOU HAVE THE FOLLOWING PROBLEMS?

	Y	N		Y	N
Eye problems	__	__	Bladder/Kidney problems	__	__
Headaches	__	__	Skin problems	__	__
Ear infections	__	__	Joint swelling/Arthritis	__	__
Sore throat	__	__	Hormone problems	__	__
Lung problems	__	__	Nerve / psychiatric problems	__	__
Heart problems	__	__	Diabetes/ Thyroid	__	__
High blood pressure	__	__	Fever	__	__
Stomach problems	__	__	Weight loss	__	__
Diarrhea	__	__	Blood Problems	__	__
Hepatitis	__	__			

Name of the person filling out this history form (if not the patient and relationship)

_____

Please feel comfortable to use as much space as you need to help us understand your problems and most pressing concerns.

_____

_____

_____

_____

_____

_____

Thank you very much!!

Patient's name_____

Please read this page and sign it , thank you.

It is your responsibility to know your insurance policy and provisions.
If your insurance requires a referral from a primary care physician, please verify that your referral is valid for the date of your visit.

If you are required to have a referral, and chose to come to our office without a referral you are coming in as a private pay patient and will be billed accordingly.

Many insurance plans have annual deductibles or percentages that the patient is responsible for above and beyond the office visit co pay.
You will be billed accordingly.

I have read the above and know that I am responsible for following my insurance company policies and I am financially responsible for all charges incurred.

_____
Printed name of the insured

_____
Signature of Insured
or Responsible Party

Credit Card Payment
Paul M.Goldberg, D.O.
1225 Martha Custis Drive, C-7
Alexandria, VA 22302
Virginia 703-998-5676 or Maryland 301-670-8338
Fax to: 301-670-8339, or mail to above address.
The information may also be called to the above phone numbers.
==========

Today's date_____
Type of credit card _____Visa, ____Master, _____ AmEx,_____ Discover

Credit Card Number_____
Expiration Date _____

Name of Patient the payment is being applied to_____

Name as it appears on Credit Card_____
Address where Credit card bills are sent:
Street address_____
City_____
State_____ Zip_____

Phone # if we need to contact you about this transaction_____

Total amount you are paying to Dr. Goldberg on this transaction $_____
Please print the above amount_____

_____
Signature of cardholder

Paul M. Goldberg, D.O., P.C.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you get access to this information. PLEASE REVIEW IT CAREFULLY

I. We have a legal duty to safeguard your Protected Health Information (PHI)

We are required to protect the privacy of your health information. This (PHI) includes what can be used to identify you that we've created or received about your past, present or future health or condition, the provision of health care to you, or payment for this health care. We must provide you with this notice about our privacy practice that explains how, when and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are required to follow the privacy practices that are described in this section.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice on our website, or in the office.

II. How we may use and disclose your protected health information.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below we describe different categories of our uses and discloses.

A. **We may use or disclose your PHI for the following reasons: treatment, payment and healthcare operations**.
   1. **For treatment**. We may disclose your PHI to physicians, PAs, nurses and other health care personnel who provide you with health care services or are involved in your care.
   2. **To obtain payment for treatment**. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you.
   3. **For health care operations**. We may disclose your PHI in order to operate this facility.

B. **Certain uses and disclosures do not require your authorization.** We may use **and disclose your PHI without your authorization for the following reasons:**
   1. When required by federal, state or local law, judicial or administrative proceedings, or law enforcement.
   2. For public health activities
   3. For health oversight activities
   4. For research purposes
   5. To avoid harm
   6. For specific government functions
   7. For workers' compensation purposes
   8. Appointment reminder and health related benefits or services
   9. For purpose of organ donation

C. **Use and disclosures require you to have the opportunity to object.** We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part in writing to our officer. The opportunity to consent may be obtained retroactively in emergency situation. If you allow another person to schedule your appointments, or make payments on your behalf, we will take it that those persons are allowed access to your PHI. (for example: a spouse or significant other , or parent of college student scheduling appointments, or paying bills are people we will also relate your PHI)

D. **All other use and disclosures require your prior written authorization**. In any other situation not described in Sections II A, B, and C above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing, to stop any future uses and disclosures (to the extent that we haven't taken any action relying on the authorization).

III. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The right to request restrictions on certain uses and disclosures of protected health information.
B. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means so long as we can easily provide it in the format you request.
C. The right to inspect and see copies of your protected health information, but you must make the request in writing.
D. The right to get a list of certain disclosures we have made.
E. The right to correct or update your protected health information
F. The right to obtain a paper copy of this notice from us upon request.

IV. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of Department of Health and Human Services, please contact: Office Manager, Paul M Goldberg, DO, 6282 Montrose Road, Rockville, MD 20852, phone 301-670-8338.

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the Office Manager above. You may also send a written complaint to the Secretary of the Department of Health and Human Services:

Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
1-800-368-1019
www.hhs.gov/ocr/hipaa

Paul M. Goldberg, D.O., P.C.

I have reviewed a copy of the Notice of Privacy Practices of Paul M. Goldberg, D.O., P.C. and understand that I will be contacted by phone, email, text, mail or ans. machine, or message with one of the people below.

Date: _____

Name:_____ _____
Printed Name Signature

Listed below are the people who can have access to my PHI:

Spouse –Printed Name _____

Phone # to reach above person _____

Partner-Printed Name _____

Phone # to reach above person _____

Parents Printed names _____ and phone #_____

_____ Phone #_____

Children (18 or older) names and phone #s

_____

_____

Other, including relationship and phone _____