Goldberg Allergy
Paul M. Goldberg, D.O.

1225 Martha Custis Drive, C-7
Alexandria, VA 22302
703-998-5676

1201 Seven Locks Rd # 216
Rockville, MD 20854
301-670-8338

5530 Wisconsin Ave # 1045
Chevy Chase, MD 20815
301-670-8338

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, photo I.D. 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 with the child in the waiting area while you are with the doctor.

Co payment is due at the time of the service. If you do not know your specialist copay, please check before coming to your appointment**. If you are paying** with a credit card, **please fill out the credit card form** as the credit card payment is run in our administrative office the next day. We also accept checks and cash copayments.
Dr. Goldberg does not double book, therefore, promptness is appreciated.
Please arrive 10 minutes before your appointment time.
Our office policy requires 24 hours notice if you must cancel your appointment to avoid a fee.

Patient_____
Day of Appointment _____
Time of appointment ____:____

CREDIT CARD PAYMENT

Our administrative office runs the credit cards, they are not swiped at the office.

Please fill out the information below for payment using credit card or HSA account

Today's Date _____

Type of Credit Card ☐Visa ☐Master ☐Am Ex ☐Discover

CREDIT CARD NUMBER _____

Expiration Date _____/_____

Name of Patient who the payment is being applied _____

Name on the Credit Card _____

Address where credit card bills are mailed to:

Street Address _____
City _____

State _____ ZIP _____

Phone # if we need to contact you about this transaction _____/ _____-_____

Total amount you want to pay today $_____

Would you like this to be kept on file for future charges? We do not put this on the internet. ☐YES ☐NO

_____
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 disclosures.

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, or your insurance company may ask for this information for their auditing and renewals.
2. To obtain payment for treatment: We may use and disclose your PHI in order to bill and collect payment for 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 procedings 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 you PHI. (for example: a spouse, or significant other, or parent of college student scheduling appointment, or paying bills, or caregivers booking or sitting in with you on your appointment, a step parent who brings you to an appointment, all of these are people we will also relate your PHI)

D. All other use and disclosures require your prior written authorization. In any other situation no 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 our 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 do 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 PHI
B. The right to reasonable requests to receive confidential communications of PHI 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 PHI 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 PHI
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 practice.

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 , 1201 Seven Locks Road, Rockville, MD 20854, 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 Secretary of Dept. of Health and human Services: Office of Civil Rights, 200 Independence Avenue, S.W., Washington, DC 20201 phone 1-800-368-1019 www.hhs.gov/ocr/hipaa

Privacy Practices Acknowledgment

I have reviewed a copy of the Notice of Privacy Practices of Paul M. Goldberg, D.O., PC.
WE MAY CONTACT YOU VIA PHONE, EMAIL, VOICE OR TEXT MESSAGE, MAIL

DATE:_____

NAME OF PATIENT (printed) _____

_____
SIGNATURE of patient or parent/guardian

Listed below are people who can have access to my PHI and who we may speak with regarding this patient

NAME	RELATIONSHIP	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Date___/___/___ AGE ____ Referred or learned of us by _____
Identifying Gender M __F__ Date of Birth ___/___/____ Marital Status_____
Patient Last Name _____First_____M.I.____
Street Address_____
City_____State_____ZIP_____
PHONE: CELL_____WORK:_____HOME:_____
EMAIL: _____
Place of Employment _____ Full / Parttime
Address of Employer _____
Student Status: N/A Full/ Parttime SCHOOL Attending_____
Please list one designated representative who we may contact concerning your issues who does not live with you. Initial here ____
Name&relation_____Phone_____

INSURANCE INFORMATION- primary

Do you have medical insurance? YES____NO____ If no payment in full due at visit
Name and date of birth of insured ___/___/___ _____
Relationship to insured, self / spouse/ child/ other _____
Insurance company_____phone_____
Ins. Co. Claims mailing address _____

INSURANCE INFORMATION – secondary

Name and date of birth of insured ___/___/___ _____
Relationship to insured, self / spouse/ child/ other _____
Insurance company_____phone_____
Ins. Co. Claims mailing address _____

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 for dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for 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 Medicare, Tricare or any private insurance company to pay and hereby assign directly to Paul M. Goldberg, D.O., 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 Paul M. Goldberg, D.O. Will be credited to my account, in accordance with the above said assignment.

_____ _____ _____
Signature Date / / Printed Name

Patient Name _____
Please read this page and sign it.

Insurance, Referral, Deductible

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.

X_____ X _____
Signature of Insured or Responsible Party Printed name of the insured

Missed Appointment Fee

Our office books only one patient in each time slot and therefore requests the courtesy of at least 24 hours notice if you cannot keep your appointment. This allows people on the waiting list an opportunity to be seen sooner. If you do not show up for your appointment (no-show) or if you cancel and reschedule with less than 24 hours notice, a $50.00 fee will be charged to you for payment. This applies to new and return patient appointments. This does not apply to allergy shots which are on a walk in basis.

I have read the above missed appointment fee policy and understand my financial responsibility if I do not show up or if I cancel without 24 hours notice.

X_____ X _____
Signature of Insured or Responsible Party Printed name of the insured

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

New Patient Form-4 pages

Date: _____ Patient's name: _____ Age: _____
Pharmacy Name: _____ Phone #: _____ If referred, by whom_____
Primary Care Physician: _____
1. **Please list your top 3 concerns to discuss this visit,** #1 being the most severe.

__itchy eyes
__sneezing
__runny nose
__stuffy nose
__postnasal drip
__ear popping
__headache
__other_____

__cough
__chest tightness
__wheezing
__itching of skin
__food allergy
__throat clearing
__drug allergy

DO NOT WRITE ON THIS SIDE

Please List all of your medications including over-the-counter or provide them on a separate sheet

1. _____ **5.** _____
2. _____ **6.** _____
3. _____ **7.** _____
4. _____ **8.** _____

For all of the following questions, check (☑) if positive or symptomatic, otherwise leave unchecked (☐)

EYES
Itchy eyes ☐
Excessive tearing, watery eyes ☐
Red Eyes ☐

NOSE
A congested, stuffy nose ☐
A watery nose ☐
A lot of post-nasal drip ☐
A discolored post-nasal drip (Green, Yellow, or Brown) ☐
The need to clear your throat ☐
An itchy throat or upper palate ☐
A loss of sense of smell or taste ☐
A cough that lasts for a month or more ☐
A history of nasal polyps ☐
Sinus pain, pressure, or recurrent sinus ☐

THROAT

Sore throat ☐

DO NOT WRITE ON THIS SIDE

EARS

Frequent earaches ☐

Ears that pop ☐

LUNGS

Attacks of wheezing or coughing ☐

Episodes of shortness of breath ☐

Increased production of mucous ☐

Prolonged bouts of coughing, especially after exercise or laughing ☐

Has a diagnosis of asthma ever been made? ☐

Have you used any steroids or cortisone drugs? ☐

If so, please specify_____

Do you get burning in your stomach? ☐

If so, when? _____

(ASTHMA CONTROL TEST) Complete if Asthmatic

1) In the past **4 weeks,** how much of the time did your **asthma** keep you from getting as much done at work school, or home?
   - ☐ All of the time [1]
   - ☐ Most of the time [2]
   - ☐ Some of the time [3]
   - ☐ A little of the time [4]
   - ☐ None of the time [5] SCORE: _

2) During the past **4 weeks,** how often have you had shortness of breath?
   - ☐ More than once a day [1]
   - ☐ Once a day [2]
   - ☐ 3 to 6 times a week [3]
   - ☐ Once or twice a week [4]
   - ☐ Not at all [5] SCORE: _

3) During the past **4 weeks,** how often did your **asthma** symptoms (wheezing, coughing, shortness of breath, chest tightness, or pain) wake you up at night or earlie than usual in the morning?
   - ☐ 4 or more nights a week [1]
   - ☐ 2 or 3 nights a week [2]
   - ☐ Once a week [3]
   - ☐ Once or twice [4]
   - ☐ Not at all [5] SCORE: _

DO NOT WRITE ON THIS SIDE

4) During the past **4 weeks,** how often have you used your rescue inhaler or nebulizer medication (such as albuterol, Ventolin®, Proventil®, or Maxair®)?

- ☐ 3 or more times a day [1]
- ☐ 1 or 2 times a day [2]
- ☐ 2 or 3 times a week [3]
- ☐ Once a week [4]
- ☐ Not at all [5] SCORE: ____

5) How would you rate your **asthma** control during the **past 4 weeks**?

- ☐ Not controlled at all [1]
- ☐ Poorly controlled [2]
- ☐ Somewhat controlled [3]
- ☐ Well controlled [4]
- ☐ Completely controlled [5] SCORE: ____

TOTAL SCORE:____

SKIN

Skin itches intensely	☐
Patches or blotches which appear and disappear within 24 hours - Hives	☐
A history of eczema as a child	☐
A history of swelling around your lips, or tongue which made it hard to breathe	☐

HIVES/WELTS

Few times per day	☐	Worse with anxiety	☐
Few times per week	☐	Worse with exercise	☐
All over body	☐	Worse with cold	☐
Joint Pain	☐	Worse with heat	☐
Stomach aches	☐	Worse with certain foods	☐
Swelling of body parts	☐	Occurs with rubbing	☐

FOOD ALLERGIES

1. A food allergy ☐

   if so, specify symptoms and foods

   _____

   _____

PAST MEDICAL HISTORY

Please list any other medical problems _____

_____

Please list hospitalizations, surgeries, and dates _____

_____

Have you had allergy testing? (Check) ☐ **YES** ☐ **NO**

Have you had allergy shots? (Check) ☐ **YES** ☐ **NO**

Please list any medication allergies and type of reaction (i.e. rash, breathing, etc.)

Medication Allergies	Type of Reaction
_____	_____
_____	_____

FAMILY HISTORY

	Allergies	**Asthma**	**Other**
Mother	☐	☐	☐
Father	☐	☐	☐
Sister	☐	☐	☐
Brother	☐	☐	☐
Children	☐	☐	☐

ENVIRONMENTAL HISTORY

Does your home contain:

Cat	☐	Wall to wall rugs	☐
Dog	☐	Hardwood floors	☐
Other pets	☐	Central A/C	☐

SOCIAL HISTORY

1. Do you smoke? ☐
   If so, how much, and how long? _____
2. Do you live with smokers? ☐
3. Immunizations up to date? YES ☐ NO ☐
4. Occupation: _____
5. Hobbies: _____
   _____
6. Alcohol use? YES ☐ NO ☐
   If YES, how much? _____
7. Days of school or work missed in the past year _____

DO YOU HAVE ANY ADDITIONAL PROBLEMS/SYMPTOMS?

Eye problems	☐	Bladder/Kidney problems	☐
Headaches	☐	Skin problems	☐
Ear infections	☐	Joint swelling/Arthritis	☐
Sore throat	☐	Hormone problems	☐
Lung Problems	☐	Anxiety/depression/other if other specify:_____	☐
Heart problems	☐	Diabetes/Thyroid	☐
High blood pressure	☐	Fever	☐
Stomach reflux	☐	Weight loss	☐
Diarrhea	☐	Blood Problems	☐
		Bee sting allergies	☐
		Any other disease? if so, please specify: _____	☐

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!!!!

_____

_____