

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.

Co pay is due at the time of services. Please bring co pay in the form of check, money order or cash.

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.

Patient: _____

Day: _____

Date: _____

Time: _____

Location: 1225 Martha Custis Drive C-7 ground floor, outside entrance

Alexandria, VA 22302

Phone: 703 998-5676

Directions to Virginia Office
1225 Martha Custis Drive, C-7
Alexandria, VA 22302
703 998-5676

From route 395:

The office is located off of route 395 at the Shirlington exit
(Adjacent to the Charles Barrett Elementary School)
The Shirlington exit is one exit North of King Street
Take the Shirlington Exit
Follow the Quaker lane exit ramp
Stay on Quaker Lane until the first traffic light. Turn LEFT onto Preston Road
(The right side of the street at that light is 32nd Road)
Take Preston Road one block to the STOP SIGN
Turn LEFT at the stop sign onto Martha Custis Drive, heading in a downhill direction
Continue through, after a 4 way stop at the intersection with Gunston Road
We are located in the Parc East Hi Rise condo around the bend on the LEFT
Turn Left into our parking lot, after parking, enter the building on the front of the building, to the right of the main entrance, adjacent to the ramp.

From Old Town:

Take King Street away from the waterfront until you reach Quaker Lane
Turn RIGHT onto Quaker Lane and go about 1 mile to the light at Preston Road
Turn RIGHT onto Preston Road and continue for 1 block until the Stop Sign
Turn LEFT onto Martha Custis Drive, heading in a downhill direction
Continue through after stopping at the 4 way stop sign at Gunston Road
We are located in the Parc East Hi Rise condo around the bend on the LEFT
Turn Left into our parking lot, after parking, enter the building on the front of the building, to the right of the main entrance, adjacent to the ramp.

From Crystal City:

Take Route 1 South to South Glebe Road
At the intersection of South Glebe and West Glebe,
Turn LEFT onto West Glebe Road (near the Pizza Hut)
Bear RIGHT at the first traffic light onto Valley Drive and
Bear RIGHT onto Martha Custis Drive
Turn RIGHT into the Hi Rise which is immediately after the Charles Barrett School
Our entrance is to the Right of the main entrance, adjacent to the ramp.

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 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, N S A
Especially after exercise or laughing
- 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? _____

DO NOT WRITE ON THIS SIDE

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? _____

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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!!

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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 _____