GOLDSON MEDICAL ASSOCIATES, LLC

20 Valley Street, Suite 320 · South Orange, NJ 07079
Phone: 973-313-1113 · Web Address: www.goldson-medical.yourmd.com

PATIENT INFORMATION

Name: (First) (Last) (Middle)

Date of Birth: Age: Sex: □ Male □ Female
SS #: - - Marital Status: □ Married □ Single □ Widowed □ Divorced
Street Address: (City/State) (Zip Code)

Home Phone#: Work #: Cell #:
Email Address:
Employer name: Employer Phone#:
Pharmacy Name: Pharmacy Phone #:
Emergency Contact: (Name) (Phone #) (Relation)

How did you hear of us? □Friend □Ad □Web □Doctor_____ □Other_____

GUARANTOR (Person responsible for bill). If same as above, write "Same"

Name: SS#: Date of Birth:
Relation: Phone#:
Address:

INSURANCE INFORMATION

Please complete all insurance details to ensure correct billing information.

Insurance Name: Phone #:
Address: (City/State) (Zip Code)

Subscriber: Subscriber DOB: Relation:

RELEASE AND ASSIGNMENT:

I, the undersigned, certify that I, or any dependent, have insurance coverage with the above mentioned and I have assigned directly to Goldson Medical Associates, LLC my insurance benefits. For anything otherwise, I am responsible for payment of services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Goldson Medical Associates, LLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Finance Charges:

I understand that a finance charge of 1.5% monthly (18% annually) will be imposed on each item of my account that has not been paid within sixty (60) days. I understand that in addition to interest charges for past due bills, I will be responsible for costs related to collection of past due bills (including collection agency fees and attorney fees).

Missed Appointments:

In the event of a missed or no-show appointment, there will be a fee of $30 unless there is notification of cancellation (24 hours prior to the scheduled appointment).

Signature: _____ Date: _____

Medical History Form

Name: (Last, First, Middle) _____ Date of Birth: _____

Home Address: (Street) _____

_____

Age: _____ Sex: □ Male □ Female

How do you rate your health: □ Excellent □ Good □ Fair □ Poor

Present Health Concerns: _____

_____

_____

Reason for your visit today (if same as above, write "Same"): _____

_____

_____

Current Medications: (Prescription and non-prescription durgs, vitamins, herbs, birth control, "patches". Please also include doses and how often medicine is taken)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies and Reaction to Medications:

_____ _____

_____ _____

_____ _____

Family History

	Living	Dead	Age	Chronic Conditions/Cause of Deat
Father				
Mother				
Sisters (# _____)				
Brothers (# _____)				

Social History:

Occupation _____

Exposure to chemicals/fumes/asbestos □ Currently □Past □Never

Smoking: □ Currently □Past □Never # of packs/day

Alcohol: □ Currently □Past □Never # of drinks/day

Other _____

With whom do you live? _____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widow(er)

Past Surgical History	Why was surgery performed?	Date (year)

Past/Current Medical History

Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know
Anemia				Hepatitis			
Angina				Herpes infection			
Arthritis				High Blood Pressure			
Asthma				HIV infection			
Bleeding problems				Hyperthyroid (Overactive)			
Blindness				Hypothyroid (Underactive)			
Cancer (Type_____)				Kidney Stones			
Cataracts				Other Kidney disease			
Chicken Pox				Measles			
Chronic Bronchitis				Migraine or chronic HA			
Cirrhosis				Mumps			
Colon or bowel trouble				Phlebitis or Blood Clots			
Deafness				Polio			
Depression				Recurrent urinary infections			
Other psychiatric illness				Rheumatic fever			
Diabetes				Rubella			
Emphysema				Seizures or convulsions			
Enlarged heart or CHF				Sinusitis			
Gall stones				Skin problems			
Glaucoma				Stomach or Duodenal Ulcers			
Goiter				Stroke			
Gonorrhea				Syphilis or VD			
Gout				TB or positive TB test			
Hay fever, allergies				Other			
Heart Attack				Other			
Heart murmur							
Hemorrhoids							

Women's Health History

Date of last menstrual Period _____ Concerns about Menopause? □Yes □ No

Age at time of first period? _____ Age at time of last period? _____

Duration of period? _____ Frequency? _____

History of Abnormal Pap smears? □Yes □ No

Are you sexually active? □Yes □ No Method of Contraception? _____

Total # of pregnancies? _____ Deliveries? _____ Miscarriages? _____ Abortions?____

Men's Health History?

Are you sexually active? □Yes □ No Method of Contraception? _____

Erectile Dysfunction? □Yes □ No

Prostate problems? □Yes □ No

Review of Symptoms: (Please check mark in appropriate squares)

Constitutional/Endocrine	Present	Past	Never
Fever/Chills	☐	☐	☐
Excess weight loss/gain	☐	☐	☐
Weakness	☐	☐	☐
Loss of energy	☐	☐	☐
Excessive thirst	☐	☐	☐
Loss of appetite	☐	☐	☐
Change in Vision	☐	☐	☐

Cardiovascular	Present	Past	Never
Chest Pain/Discomfort	☐	☐	☐
Leg pain with exercise	☐	☐	☐
Palpitations	☐	☐	☐
"Skipped" heart beats	☐	☐	☐
Ankle swelling	☐	☐	☐
Easier to breathe sitting up	☐	☐	☐

Pulmonary (Lungs)	Present	Past	Never
Difficulty breathing	☐	☐	☐
Chronic Cough	☐	☐	☐
Spit up blood	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Tuberculosis	☐	☐	☐
Other	☐	☐	☐

Gastrointestinal	Present	Past	Never
Abdominal Pain	☐	☐	☐
Blood in stool	☐	☐	☐
Nauea/Vomiting	☐	☐	☐
Diarrhea	☐	☐	☐
Black Tarry Stools	☐	☐	☐
Vomiting blood	☐	☐	☐
Heartburn	☐	☐	☐
Constipation	☐	☐	☐
Hemorrhoids	☐	☐	☐

Musculoskeletal	Present	Past	Never
Muscle pain	☐	☐	☐
Joint Pain	☐	☐	☐
Limited joint movement	☐	☐	☐
Joint swelling	☐	☐	☐

Genitourinary	Present	Past	Never
Excess Urination	☐	☐	☐
Pain with urination	☐	☐	☐
"Leakage" of urine	☐	☐	☐
Frequent urination at night	☐	☐	☐
Difficulty initiating stream	☐	☐	☐
Blood in urine	☐	☐	☐
Genital discharge	☐	☐	☐
Difficulty achieving erection	☐	☐	☐

Nervous system	Present	Past	Never
Loss of coordination	☐	☐	☐
Tingling sensation	☐	☐	☐
Numbness	☐	☐	☐
Paralysis	☐	☐	☐
Memory Loss	☐	☐	☐
Seizures	☐	☐	☐

Breast	Present	Past	Never
Lumps or masses	☐	☐	☐
Nipple Dischareg	☐	☐	☐
Skin changes	☐	☐	☐

Psychiatric	Present	Past	Never
Depressed mood	☐	☐	☐
Difficulty sleeping	☐	☐	☐
Decreased energy	☐	☐	☐

Other

Effective Date of this Notice:_____

GOLDSON MEDICAL ASSOCIATES, LLC

20 Valley Street, Suite 320
South Orange, NJ 07079

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, have received a copy of Goldson Medical Associates, LLC's Notice of Privacy Practices.

_____ _____

Signature of Patient Date

Effective Date of this Notice:_____

GOLDSON MEDICAL ASSOCIATES, LLC

20 Valley Street, Suite 320
South Orange, NJ 07079

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Goldson Medical Associates, LLC at 973-313-1113

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders, Treatment Options, Health-Related Benefits and Services. Our practice may use and disclose your IIHI to contact you and remind you of an appointment., to inform you of potential treatment options or alternatives and/or to inform you of health-related benefits or services that may be of interest to you.

5. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take a child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

6. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. We may disclose your health information for public health activities to prevent or control disease, injury or disability. We may use your health information in reporting births or deaths, suspected child abuse or neglect, medication reactions or product malfunctions or injuries, and product recall notifications. We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. If we are concerned that a patient may have been a victim of abuse, neglect, or domestic violence we may ask your permission to make a disclosure to an appropriate government authority. We will make that disclosure only when you agree or when required or authorized to do so by law.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain a court or administrative order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official: 1) Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement; 2) Concerning a death we believe has resulted from criminal conduct; 3) Regarding criminal conduct at our offices; 4) In response to a warrant, summons, court order, subpoena or similar legal process; 5) To identify/locate a suspect, material witness, fugitive or missing person; 6) In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

9. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

10. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

11. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Goldson Medical Associates, LLC at the above address specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Goldson Medical Associates, LLC at the above address. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Goldson Medical Associates, LLC at the above address in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or

for our practice. To request an amendment, your request must be made in writing and submitted to Goldson Medical Associates, LLC at the above address. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Goldson Medical Associates, LLC at the above address. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 17, 2006.. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Goldson Medical Associates, LLC at 973-313-1113.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Goldson Medical Associates, LLC at 973-313-1113. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the purposes described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Goldson Medical Associates, LLC at 973-313-1113.

Goldson Medical Associates, LLC
Debra Goldson-Prophete, MD
20 Valley Street, Suite 320 • South Orange, NJ 07079
Ph: 973-313-1113 • Fax: 973-313-1191

MEDICAL RECORDS REQUEST
AUTHORIZATION TO REQUEST A COPY OF MEDICAL RECORDS TO BE FORWARDED

Please print this page, read it carefully, fill it in, and sign it. Then fax, mail, or hand-deliver to the address in Step 2. *This only allows a copy of your medical records to be forwarded to this office. It does not affect your relationship with this physician.*

STEP 1- PATIENT INFORMATION

Name_____ Date of Birth _____

Social Security #: _____ Phone #: _____

Address _____

STEP 2 – CURRENT LOCATION OF RECORDS THAT YOU WANT COPIED

Name of Practice/Hospital/Doctor _____

Address _____

Telephone: _____ and/or Fax: _____

STEP 3- INFORMATION YOU WANT COPIED AND RELEASED

☐ All records *or* ☐ Dates of treatment: _____ to _____

☐ Labs ☐ Radiology reports ☐ Radiology films (specify) _____

STEP 4- LOCATION TO WHICH YOUR RECORDS SHOULD BE SENT

Name of Practice/Hospital/Doctor _____

Address _____

Telephone: _____ and/or Fax: _____

This authorization is valid for ninety (90) days and may be revoked in writing at any time prior to the expiration date.

Patient Signature _____ Date _____

Release of Sensitive Information: I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric issues, sexually transmitted diseases, social service, hepatitis testing/treatment, HIV testing/treatment and/or sensitive information, I agree to its release.

Patient Signature _____ Date: _____