Kelly Goodman, NP & Associates, PC

New Patient Information

Last Name: ____

First Name: ____ MI: _______

Date of Birth: _______________________ Phone: _______________________________

Address: ____ City: ______________Zip Code: ______

Email Address: ____

Please note: you will receive an email to set up your online portal account. Please follow directions in email to create your account. The portal will be your main form of communication with providers and administrative staff. *

Preferred Pharmacy: ____

In addition to providing primary care, we offer a variety of skin care and cosmetic procedures. Is this something you would be interested in learning more about? **Yes / No**

Emergency Contact Information:

Name: ____

Phone: ________________________________ Relationship to Patient: ______________________________

PATIENT HEALTH RECORD

Name:____ Date:_______________________________

Medical History (This confidential information helps us determine proper treatment and medication):

Please indicate if you have ever had/or still have any of the following:			
	AIDS/HIV infection		Hepatitis/Jaundice
	Anemia		Herpes
	Artificial heart Valves		High/low blood pressure
	Artificial joints/implants		Hives/skin rashes
	Asthma		Kidney disease
	Back or neck problems		Liver disease
	Bruise or bleed easily		Pacemaker
	Bulimia or anorexia		Psychiatric treatment
	Cancer/tumor		Rheumatic fever
	Chemical Dependency		Seizures
	Chest pain		Scarlet fever
	Cortisone treatment		Shortness of breath
	Diabetes		Sickle cell anemia
	Epilepsy/neurological problems		Stomach ulcers
	Fainting or dizzy spells		Stroke
	Glaucoma		Phlebitis
	Heart Disease		Thyroid Disease
	Mitral Valve Prolapse		Ulcers
	Heart murmur		Other:
	Gout		Other:

Are you allergic to: ❑ Penicillin ❑ Codeine ❑ Local Anesthetics ❑ Latex ❑Other:_____________________________

Have you been treated in the hospital in the past two years? ❑ Yes ❑ No

If yes, please write reason for admittance:____

Please list all prescription drugs you are taking:

Has your Physician advised you to pre-medicate before dental treatment? ❑ Yes ❑ No

Are you taking hormones or birth control? ❑ Yes ❑ No

Have you ever had a blood test for hepatitis? ❑ Yes ❑ No

Do you use tobacco? ❑ Yes ❑ No

Have you had surgery? ❑ Yes ❑ No

If yes, please list type of surgery and year the procedure was done:

Do you take vitamins regularly? ❑ Yes ❑ No

Are you pregnant or nursing? ❑ Yes ❑ No

Have you been vaccinated for hepatitis? ❑ Yes ❑ No

Do you consume alcohol? ❑ Yes ❑ No

Please tick the box if any immediate family members have any of the following:

❑ Arthritis ❑ Cancer ❑ Diabetes ❑ Heart Disease ❑ High Blood Pressure ❑ Kidney Disease ❑Obesity

I HEREBY GIVE PERMISSION TO THE PROVIDER TO EXAMINE, DIAGNOSE AND TREAT ME AND ATTEST THAT THE ABOVE INFORMATION IS ACCURATE AND TRUE.

Patient Name (Printed): ________________________________

Patient Signature: ____________________________________ Date: _______________

Kelly Goodman, NP & Associates, PC

Office Policies and Procedures: We are an appointment-based practice. All patients must make an appointment to be medically evaluated and diagnosed in person. All telecommunications from our Nurse Practitioners are limited to INTERPRETATIVE services only.

Operating Hours: Monday-Friday 7:30AM to 4:30PM, Saturday 9:00AM to 1:00PM

1. **After Hours:** If it is a Medical Emergency, call 911 immediately. For all non-emergency medical issues, please call our office and follow the phone instructions, or visit an after-hours clinic approved by your insurer. Please save other inquiries for business hours.
2. **Patient Conduct:** By signing this form, the patient agrees to comport themselves in a professional and cordial manner with all our office staff. Rude, aggressive, or other offensive behavior towards any member of our office staff will result in immediate patient dismissal.
3. **Patient Portal:** All patients under the age of 65 **must** register for a portal account. The portal enables patients to receive their lab results, view reports, request refills, and communicate with the providers through a secure, HIPAA compliant website. Patients require an email address to use this system and will receive an email notification when they receive a new health update.
4. **Service Expectations:** Please allow *at least* 3 business days for our staff to complete prior-authorization requests, records requests, prescription refill requests, and form completions. This does not include the time needed for non-practice entities to complete requests.
5. **Health Insurance:** We currently accept United Healthcare, Cigna, Aetna, Tricare, Blue Cross Blue Shield, and Medicare. We ***do not*** accept any form of Medicaid, even if it is within one of the accepted plans. It is the **patient's responsibility** to provide accurate health insurance information in the form of an insurance card at the time of the visit and to know what type of coverage their plan provides.
6. **Financial Responsibility:** By signing this form, the patient agrees to pay all co-pays, co-insurances, deductibles, outstanding balances or other fees at the time of their visit. Payment must be received before the appointment or we reserve the option to reschedule it. Our practice accepts cash, credit/debit cards, and personal checks as forms of payment. An outstanding balance that is not paid within 30 days of the patient receiving notice is considered PAST DUE and will be forwarded to a collection agency.
7. **Cancellations and No Show:** Please cancel an appointment NO LESS than 24 hours before the scheduled time. Repeated offenses to this policy will be tracked and could be subject for patient dismissal. Patient's who do not show up to their scheduled appointment and do not call to cancel or reschedule outside of the 24-hour window will be charged a **$100.00** no show fee. Patient's who call to reschedule their appointments within 24 hours of their scheduled appointment will be subject to a **$50.00** late cancellation/reschedule fee.
8. **Prescription Refills:**
   a. It is illegal to alter and/or tamper with any prescriptions written by a medical provider. Any prescription thought to be tampered with after leaving our facility will result in **IMMEDAITE dismissal** from our practice. Our office will also be required to notify the DEA as well as local law enforcement.
   b. All chronic (regularly taken) medications require regular follow-up visits at our office. Our Providers will let you know the appropriate interval between visits and schedule your next follow up appointment accordingly. If you are overdue for your visit, your provider may choose to provide you enough medication until your scheduled appointment (maximum 1 week) as a courtesy.

   c. Medications for acute problems (cough, fever, etc.) **will require** an office visit to ensure a correct diagnosis and appropriate medication is prescribed.
   d. If a patient needs a refill between office visits, please have your pharmacy send us an electronic refill request or send a request through the portal.
9. **Controlled Substances:**
   a. Any patient who is prescribed controlled substances will be subject to random urine drug screening at the providers discretion. Refusal to comply with random urine drug screening will result in immediate dismissal from our practice.
   b. All patients who receive controlled substance prescriptions from our office must be receiving them from our office ONLY. If it is brought to our attention that patients are having controlled substance prescriptions filled by more than one provider, the patient will be dismissed from our practice and the other provider(s) filling the prescriptions will be notified.
10. **Referrals:** Many insurance companies now require referrals for a patient's visit to specialists. An office visit is required for referrals.
11. **Membership Fee:** Starting in 2015, the practice charges an annual membership fee. Please ask for the fee schedule. This fee schedule is subject to change on an annual basis. It is required to be part of the practice and must be collected before being seen by a Provider, requesting prescription refills, or requesting phone consults with providers.
12. **Saturday Walk-In Clinic:** On Saturdays, our office sees patients from 9:00AM to 12:45PM. Saturday hours are walk-in only. Saturday services include: prescription refills, cold/flu/sinus symptoms, UTI's, immunizations/vaccinations, sprains, minor laceration repair. Services we do not provide on Saturdays include: adult physicals, wellness exams, hypertension, chest pain, lab work, and issues best addressed by an Emergency Room.

I hereby consent to all office policies and procedures listed in this form by signing below.

____

Patient Name (Printed)

____

Patient Signature

____

(Date)

Kelly Goodman, NP & Associates, PC

Adult Patient Consent Form for Use and Disclosure of Protected Health Information

I, ______________________________ (**Please Print Name**) hereby give my consent for Kelly Goodman NP, & Associates, PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Kelly Goodman NP & Associates describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Kelly Goodman NP & Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the practice at 4701 Sangamore Road Suite S207, Bethesda MD 20816.

With this consent, Kelly Goodman, NP & Associates, PC may call my home or other alternative location that I have provided and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Kelly Goodman, NP & Associates, PC may mail to my home or other alternative location I have provided any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Kelly Goodman, NP & Associates, PC may e-mail to the address I have provided, or through the secure electronic patient portal any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements and test results. I have the right to request that Kelly Goodman, NP & Associates, PC restrict how it uses or discloses my PHI to carry out TPO. The practice is **not required** to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I have read and understand the Notice of Privacy Practices and am consenting to allow Kelly Goodman, NP & Associates, PC to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Kelly Goodman, NP & Associates, PC may decline to provide treatment to me.

____

Print Patient's Name

______________________________ ______________________

Signature of Patient Date

Kelly Goodman, NP & Associates, PC

Medical Information Release Form (HIPAA Release Form)

Name: ____ Date of birth: ___________________________

Release of Information- I authorize the release of information including the diagnosis, records, examination rendered to me, and claims/billing information. This information may be released to (MUST CHECK ONE):

______ Spouse_____________________________________

______ Child(ren)__________________________________

____

______ Other_______________________________________

______ **Information is not to be released to anyone.**

****This *Release of Information* will remain in effect until terminated by me in writing.****

Messages - ______ my home ______ my work ______ my cell phone

If unable to reach me:

_______ leave a detailed message

_______ leave a message asking to return your call

_______ Other: ____

The best time to reach me is (*day*) _________________ between (*time*) __________________

____ ______________________

Signature Date

Online Portal - Please use the following email address for my online patient portal:

Email: ____