Jason M. Goldman, M.D., P.A.

Diplomate, American Board of Internal Medicine

PLEASE READ CAREFULLY
WELCOME TO OUR PRACTICE!!!

Appointments are very true on time, except in case of emergencies. Please be on time. Should you arrive late you may be asked to wait until the next available appointment time (if available) or be asked to reschedule.

Lab Work/Blood Work will be drawn here in our office. Labs will normally be sent to Quest Diagnostics unless specified by your insurance company. Please inform us of the lab company your insurance requires in the space below.

Lab Name: _____

> *** ***This Office has no responsibility or involvement with the billing done by outside lab, facilities or agencies.*** ***

Lab Results will be corresponded directly to you by Dr. Goldman himself. Dr. Goldman will call you via telephone upon receipt of full and final lab results. Certain testing will require you to return to the office for results and cannot be given over the phone. Lab results can only be given to you as the patient unless a release is signed by you permitting another person to receive results on your behalf.

> *** ***If it has been more than 7 days and you have not received a call with results, please call the office, please do not assume no phone call means normal results.*** ***

Diagnostic Results (X-Rays, CT Scans, MRI'S, Ultrasound) Dr. Goldman will call you via telephone upon receipt of the report(s). Diagnostic results can only be given to you as the patient unless a release is signed by you permitting another person to receive results on your behalf.

> *** ***If it has been more than 7 days and you have not received a call with results, please call the office, please do not assume no phone call means normal results.*** ***

Referrals will be processed in 5-7 business days. Some referrals may require additional time. A minimum of 48 hours' notice is required for referrals. Emergency referrals may be considered on a case by case basis. Referrals will be mailed directly to you or faxed directly to the specialist. Be sure to bring your referral to the specialist referred to you at the time of your visit.

By signing below, you have read and understand the above.

_____ _____

Patient Signature Date

3001 Coral Hills Drive, Suite #340, Coral Springs, Florida 33065

Phone: (954) 227-1234 • Fax: (954) 227-1244 • Email: goldmanmd@bellsouth.net

Jason M. Goldman, M.D., P.A., FACP

Diplomate, American Board of Internal Medicine

PATIENT INFORMATION UPDATE FORM

Please **PRINT CLEARLY** and **FILL OUT FROM COMPLETELY EVEN IF NONE OF YOUR INFORMATION HAS CHANGED** before returning to the front desk.

First Name: _____ Last Name: _____

D.O.B. _____ Phone Number: _____

Birth Sex: Male _____ Female: _____

Race: Choose one X

American Indian or Alaska Native _____ Declined to specify _____

Asian: _____

Black or African American: _____ *Other* _____

Native Hawaiian or Other Pacific Islander: _____

White: _____

Ethnicity: Choose one X

Hispanic or Latino _____ Declined to Specify _____

Not Hispanic or Latino _____ Other _____

Language Preferred: _____ Interpreter Required? Y / N

Email Address: _____

Address: _____

City: _____ State: _____

Pharmacy Name : _____

Pharmacy Phone Number: _____

Insurance Carrier: _____ Policy No: _____

_____ _____

Patient signature Date

3001 Coral Hills Drive, Suite #340, Coral Springs, Florida 33065

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Patient Information

Legal Name: _____
Address: _____
City: _____
State: _____
Zip: _____
Home Phone: _____
Work Phone: _____
Cell phone: _____
Emergency contact: _____
Relationship to patient: _____
Phone: _____

Marital Status: _____
Marital Status: _____
Sex: Male _____ Female _____
Date of birth: _____/_____/_____
Social Security Number: _____-_____-_____
Occupation: _____
Employer: _____
Address: _____
City: _____
State: _____
Zip: _____

Person Responsible for Payment *(if other than patient)*

If the policyholder is the patient then write same.

Legal Name: _____
Address: _____
City: _____
State: _____
Zip: _____
Home Phone: _____
Work Phone: _____
Relationship to patient: _____

Sex: Male _____ Female _____
Sex: Male _____ Female _____
Date of birth: _____/_____/_____
Occupation: _____
Employer: _____
Address: _____
City: _____
State: _____
Zip: _____

Primary Insurance Information

Please provide a copy of your insurance card and driver's license.

Primary Insurance: _____
Effective Date: _____
ID# _____
Group# _____
Address: _____
City: _____
State: _____
Zip: _____

Subscriber: _____
Subscriber: _____
Date of birth: _____
Social Security Number: _____-_____-_____
Relationship to patient: _____
Phone Number: _____

Secondary Insurance Information

Primary Insurance: _____
Effective Date : _____
ID# _____
Group# _____
Address: _____
City: _____
State: _____
Zip: _____

Subscriber: _____
Subscriber: _____
Date of birth: _____
Social Security Number: _____-_____-_____
Relationship to patient: _____
Phone Number: _____

Referring Physician: _____

How did you hear about our practice? _____

Allergies: _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION CONSENT TO TREATMENT AND AUTHORIZATION FOR SUBMISSION TO MEDICARE AND ALL INSURANCE CARRIERS

1. I hereby give my consent for Jason M. Goldman, M.D., P.A. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Jason M. Goldman, M.D., P.A.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

2. *I have the right to review the Notice of Privacy Practices prior to signing this consent.*
Jason M. Goldman, M.D., P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a
written request to Jason M. Goldman, M.D., P.A., Privacy Officer at 3001 Coral Hills Drive, Suite #340, Coral Springs, Florida 33065.

3. With this consent, Jason M. Goldman, M.D., P.A. may call my home or other alternative location 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 results among others.

4. With this consent, Jason M. Goldman, M.D., P.A. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

5. With this consent, Jason M. Goldman, M.D., P.A. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Jason M. Goldman, M.D., P.A. restrict how it uses or discloses my PHI to carry out TPO.

6. However, 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 am consenting to Jason M. Goldman's use and disclosure of my PHI to carry out TPO.

7. *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, Jason M. Goldman, M.D., P.A. may decline to provide treatment to me.

8. I consent to undergo all necessary tests, medication, treatment, and other procedures in the course of the study, diagnosis and treatment of my illness(s) by the medical staff of Jason M. Goldman, M.D., P.A.

9. I have been told the name of the physician who has responsibility for my care, as well as the names, professional *status and* professional relationships of other *individuals who will be involved* in my care.

10. I understand that, except in emergent or extraordinary circumstances, non-routine and major medical procedures, will not be performed upon me until I have had an opportunity to discuss and agree to them with a physician.

11. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantee have been made to me as to the results or diagnoses, examinations or treatments in the hospital or clinics.

12. I hereby authorize the staff of Jason M. Goldman, M.D., P.A. *to take such still* photographs, motion pictures, television *transmission* and/or videotaped recordings for educational and evidentiary purposes as they may wish. Any such still video images used for medical, scientific, research or educational purposes, will not reveal, where possible, my identity through the image itself or the accompanying descriptive text. I understand that I have the right to refuse any such imaging and will be notified before any such documentation is employed.

13. I hereby authorize the staff of Jason M. Goldman, M.D., P.A. to retain, preserve and/or use *for scientific, research, therapeutic, commercial, or teaching purposes* or dispose of at their convenience, any specimen or tissue taken from my body during my treatment.

14. I understand and authorize the following: use of this form on all my insurance submissions, release of information to all my insurance carriers, payment directly to my doctor, my doctor to act as my agent in helping me obtain payment from my insurance carriers, permit a copy of this authorization to be used in place of the original signature on file. This applies to Medicare beneficiaries and insured patients where applicable. In Medicare-assigned cases, the physician agrees to accept the charge of determination of the Medicare carrier as the full charge and *I agree I am responsible* for deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier. I am responsible for all out of network or non covered charges in insurance claims.

15. I understand and agree that copayment is due at time of service (coinsurance and deductibles may also be collected at the time of service). I understand I am financially responsible for charges not covered by my insurance company. I also agree to pay any outstanding balances as well as attorney fees and collection costs to practice *if this matter is referred* to collection agency.

Signature of Patient or Legal Guardian	Patient's Name
Print Name of Patient or Legal Guardian	Date

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Practice Financial Policy

Thank you for choosing Jason M. Goldman, M.D., P.A. as your health care provider. We are committed to building a successful physician-patient relationship, and the success of your medical treatment and care. Your understanding of our Practice Financial Policy and payment for services are important parts of this relationship. For your convenience, this document discusses a few commonly asked financial policy questions. If you need further information or assistance about any of these policies, please ask to speak with our Practice Manager.

When are payments due?

All copayments, deductibles, patient responsibility amounts, and past-due balances are due at the time of check-in unless previous arrangements have been made with our billing coordinator.

How may I pay?

We accept payment by cash, check, debit card and all major credit cards. We will only accept post-dated checks when they are provided within an approved payment plan.

Will you bill my insurance?

Insurance is a contract between you and your insurance company. In most cases, we are not a party to this contract. We will bill your primary insurance company on your behalf as a courtesy to you. To properly bill your insurance company, we require that you disclose all insurance information, including primary and secondary insurance, as well as any change of insurance information.

It is your responsibility to notify our office promptly of any patient information changes (ie, address, name, insurance information) to facilitate appropriate billing for the services rendered to you. Failure to provide complete and accurate insurance information may result in the entire bill being categorized as a patient's responsibility.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Which plans do you contract with?

Jason M. Goldman, M.D., P.A., accepts most major insurance plans. However, with the frequent changes that happen in the insurance marketplace, it is a good idea for you to contact your insurance company prior to your appointment and verify if we are a participating provider as per your plan.

What if my plan does not contract with you?

If we are not a provider under your insurance plan, you will be responsible for payment in full at the time of service. As a courtesy, however, we will file your initial insurance claim, and if not paid within 45 days, you will be responsible for the total bill. After your insurance company has processed your claims, any amount remaining as a credit balance will be refunded to you.

What is my financial responsibility for services?

It is your responsibility to verify that the physicians and the practice where you are seeking treatment are listed as authorized providers under your insurance plan. Your employer or insurance company should be able to provide a current provider listing.

The patient or the patient's legal representative is ultimately responsible for all charges for services rendered. "Non-covered" means that a service will not be paid for under your insurance plan. If non-covered services are provided, you will be expected to pay for these services at the time they are provided or when you receive a statement or explanation of benefits (EOB) from your insurance provider denying payment.

Your insurance company offers appeal procedures. We will not under any circumstances falsify or change a diagnosis or symptoms to convince an insurer to pay for care that is not covered, nor do we delete or change the content in the record that may prevent services from being considered covered. We cannot offer services without

expectation of payment, and if you receive non-covered services, you must agree to pay for these services if your insurance company does not. If you are unsure whether a service is covered by your plan, ultimately, it is your responsibility to call your insurance company to determine what your schedule of benefits allows, if a deductible applies, and your potential financial responsibility.

What if I don't have insurance?

Self-pay accounts are used for patients without insurance coverage, patients covered by insurance plans which the office does not accept, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating in their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to pay in full for services rendered to them and will be asked to make payment arrangements prior to services being rendered. Emergency services provided to self-pay patients will be billed to the patient.

At the sole discretion of the practice, extended payment arrangements may be made for patients. Please speak with our practice manager to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and reasonable costs.

I received a bill even though I have secondary insurance.

Having secondary insurance does not necessarily mean that your services are 100% covered. Secondary insurance policies typically pay according to a coordination of benefits with the primary insurance.

What if I have billing or insurance questions?

Jason M. Goldman, M.D., P.A. is supported by a staff of dedicated professionals. Our office staff can assist with most financial questions and help relieve the patient/caregiver of burdensome paperwork. Please ask if you have any questions about our fees, our policies, or your responsibilities.

Do you bill other third parties?

We do not bill third parties for services rendered to you. Our relationship is with you and not with the third-party liability insurer or policy carrier (eg, auto or homeowner). It is your responsibility to seek reimbursement from them. However, at your request, we will submit a claim to your primary health insurance carrier. You will be asked to pay in full for the services we provide you. All formalities required by your insurer and the third party should be promptly completed by you. If we receive a denial of your claim, you will be responsible for payment in full.

What if my insurance pays late?

As a courtesy to you, we bill your insurance company for services on your behalf. If any insurance company fails to process payment for services within 45 days from the date of the claim submission, the total balance will be determined to be the patient's responsibility.

Will I receive statements or bills?

It is our office policy that all accounts with pending balances be sent two statements, each one month apart. If payment is not made on the account, a single phone call will be made to try and make payment arrangements. Accounts with unpaid balances for 90 calendar days or more will be sent to an external collection agency or attorney for collection. Unpaid bills can also lead to possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for the collection's costs, including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office if you are 18 years old or older and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

Do you refer unpaid bills to collection agencies?

If a patient cannot pay the balance on their account according to the financial policy will be referred to an outside collection agency or an attorney for further action.

Do you charge a penalty for returned payments?

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Any charges incurred by the practice collecting balances owed to us during the collection process may be charged to the patient. Returned checks, credit card chargebacks, or returned payments will attract a minimum $35 penalty in addition to the balance owed. Accounts with returned payments will be expected to make payments via cash, money order, or cashier's checks only.

Can you waive my copay?

We cannot waive deductibles, coinsurances, or copays that are required by your insurance. This is a violation of insurance rules.

I have a hardship. How can you help me?

Some patients may accrue large balances for services provided. At the sole discretion of the practice leadership, we will work with you to set up a mutually feasible payment plan. In some cases, if the minimum payment due cannot be paid, we will need proof of financial hardship. We may be forced to pursue collections of balances in the absence of tangible proof of hardship.

Do you charge for completing forms?

Completing disability forms, FMLA forms, and other requested supplemental insurance forms requires time away from patient care and day-to-day business operations. A payment of $15.00 per form is required. Please understand that to complete forms, your medical record must be reviewed, forms completed and signed by the physician and copied into your medical record. Some of these forms can be quite complicated and tedious to fill out. Please provide us with pertinent information, especially dates of disability and return to work. We request that you allow 5 business days for this process.

Do you charge for copies of medical records?

The following costs are within the Florida statues 395.3025, Rule 64B8-10.003, of the Florida administrative code.

Patients will be charged

- $1.00 per page for the first 25 pages then $0.25 for every page after that

Attorneys Life Insurance Companies

- $1.00 per page

Expedited requests will be charged a special handling fee.

What if I missed my appointment to see the physician?

We understand that on rare occasions, issues may arise, causing you to miss your appointment when you cannot notify our office before your appointment. Should you experience any unforeseen circumstance that causes you to miss your appointment, please call our office at least 24 hours prior to having it rescheduled.

Our highly skilled physicians are committed to your well-being and have reserved time just for you. Patients who miss more than one appointment without notifying our office 24 hours before the appointment time are subject to a $50 missed appointment fee billed to the patient.

I have read, understand, and agree to the above Financial Policy. I understand my financial responsibility to make payments for services provided to me and the courtesy extended by office to simplify insurance reimbursement for the services provided to me. I acknowledge that these policies do not obligate to extend credit to me for services provided.

Patient or authorized representative signature: _____ **Date:** _____

Patient or authorized representative name: _____

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Authorization for Release of Protected Health Information (PHI)

Section A: This section must be completed for all Authorizations for Release of Right to Access			
Patient Name:	Birth Date:	SS#	
Patient's Address:		**Requester's Name:** **Jason M. Goldman, M.D., P.A.**	
City, State, Zip:		**Requester's Address** **3001 Coral Hills Dr. Suite 340** **Coral Springs, Florida 33065**	
Records Requested From:	Address:	State, Zip:	Phone/Fax:
This Authorization will expire on (date or event):			
Purpose of Discloser: **MEDICAL TREATMENT**			

Description of information to be Disclosed

_____ **ALL PHI**	_____Physician Orders	_____ Demographics
_____ History/Physical	_____ Laboratory	_____Rehab
_____ Consults	_____ Imaging/X-ray	_____ Special Tests
_____ Operative Report	_____ Nursing Notes	_____Bill/Claim Forms
_____ Progress Notes	_____ Medications	_____ Other:_____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *Initial:*_____

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my healthcare and the payment for my healthcare will not be affected unless stated otherwise in section C.
3. I may revoke this authorization anytime in writing, but if I do, it will not have any affect on any actions taken prior to received the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health paln or healthcare provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I will receive a copy of this form after I sign it.

Section B: Is the Requester of this PHI another health plan or health care provider? Yes _____ No _____
If yes, the health plan or healthcare provider must complete Section B, otherwise skip to Section C.

What is the purpose if this use of disclosure? **Medical Records for Medical Care & Treatment**

Will the requester receive financial or in in-kind compensation in exchange for using or disclosing this information? **No**

Will the Requester plan to obtain the patient's consent and/or provide a notice of privacy practices?
Yes, then all statements above are binding

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as states.

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient:

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RECORDS RELEASE
(AUTHORIZATION FORM)

I _____(patient name) grant permission to Dr. Jason M. Goldman, MD to disclose to:

_____
Name

_____
Name

_____
Name

Complete information concerning my medical findings and treatment from _____(date) to _____(date).

I release Jason M. Goldman from any laws related to disclosure of confidential or privileged information.

_____ _____
Patients Signature Date

_____ _____
Parent/Guardian Date

***Persons under the age of 18 must have authorization form signed by a parent and/or guardian)

_____ _____
Witness Date

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ARES Questionnaire

PRINT IN CAPITAL LETTERS- STAY WITHIN THE BOX (Physician Use Only)

NAME:	DATE:				Tally ARES Risk Pts
WEIGHT	POUNDS	AGE		GENDER: MALE __ FEMALE__	Neck Size +2 male ≥ 16.5 +2 female ≥ 15.0
HEIGHT	FEET	INCHES	NECK SIZE	INCHES	
DATE OF BIRTH	MONTH	DAY	YEAR	ID NUMBER OPTIONAL	Score

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION- ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?				Co-morbidities
High Blood Pressure Yes○ No○		Stroke Yes○ No○		+1 for each yes
Heart Disease Yes○ No○		Depression Yes○ No○		Score
Diabetes Yes○ No○		Sleep Apnea Yes○ No○		
Lung Disease	Yes○ No○	Nasal oxygen use	Yes○ No○	Do not assign any points for these eight responses.
Insomnia	Yes○ No○	Restless leg syndrome	Yes○ No○	
Narcolepsy	Yes○ No○	Morning Headaches	Yes○ No○	
Sleeping Medication	Yes○ No○	Pain Medication(eg vicodin, oxycontin)	Yes○ No○	

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation.

0= would never doze 1= slight chance of dozing
2= moderate chance of dozing 3= high chance of dozing

	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (theater, meeting, etc)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon when circumstances *permit*	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after lunch without alcohol	○	○	○	○
In a car, *while* stopped for a few minutes in traffic	○	○	○	○

Epworth Score

TOTAL the values from all 8 questions. If 11 or less Score=0 If 12 or more Score=2

Score

Frequency 0-1 times/week 2 times/week 3-4 times/week 5-7 times/week

On average in the past month, how often have you snored or been told that you snored?
Never○ Rarely○+1 Sometimes○+2 Frequently○ +3 Almost Always○ +4

Do you wake up choking or gasping?
Never○ Rarely○+1 Sometimes○ +2 Frequently○ +3 Almost Always○ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never○ Rarely○ +1 Sometimes○+2 Frequently○+3 Almost Always ○+4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never○ Rarely○+1 Sometimes○+2 Frequently○+3 Almost Always ○+4

Assign points for each of the *first* **three** responses

Signature	Telephone Number	Total all 6 boxes from above If point total = 4 or 5 (low risk), 6-10 (high) & 11 or more (very high)	SCORE

Your hearing is important to your overall health and safety, which is why physicians recommend patients have their hearing tested annually. We're excited to share that our office is now offering convenient in-house hearing services. Please take a moment to answer the following four questions.

Patient Name: _____
(Please print)

Date of Birth: _____

Phone Number: _____

Email: _____

Yes	No	Hearing Questionnaire
☐	☐	1. Do you feel frustrated when talking to members of your family or co-workers because you have difficulty understanding them?
☐	☐	2. Do you find that it's difficult to communicate with friends in a restaurant setting?
☐	☐	3. Do you (or does someone in your family) suspect that you need help with your hearing?
☐	☐	4. Do you have trouble hearing the TV or radio at levels that are loud enough for others?

Adopted from: https://www.nidcd.nih.gov/health/do-you-need-hearing-test

If you answered yes to any of these questions, we would like to schedule you for a complimentary hearing evaluation with one of our licensed Hearing Service Providers.

For your complimentary hearing test, please schedule by calling us at

833-746-1234