REPRODUCTIVE HEALTH PHYSICIANS

Neil F. Goodman, M.D., F.A.C.E

Hara Rosen Berger, D.O.

Patient Name: _____**Nickname**_____

Date of Birth: _____ **Age:** _____ **Sex: M** _____ **F** _____ **T** _____

Address: _____ **City** _____ **State**_____

Zip_____ **SS#:** _____ **Marital Status:** ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed**

Phone: Cell (_____**)**_____ **Home (**_____**)**_____

E-mail: _____ **Pharmacy Phone #:** _____

Place of employment: _____ **Work (**_____**)**_____

Spouse/ Responsible Party: _____

Date of Birth: _____ **SS#:** _____ **Sex: M** _____ **F**_____ **T**_____

Phone: Cell (_____**)**_____ **Home (**_____**)**_____

Place of employment: _____ **Work (**_____**)**_____

Referred by:_____ **Reason for seeing doctor:** _____

Allergies: _____

Current Medications: _____

Medical Insurance: ☐ **Yes** ☐ **No** **Company Name:** _____

Please read and sign below.

Billing your insurance company is done as a courtesy to you, our patient, and is not to dismiss your responsibility. It is your ultimate responsibility (patient or responsible party) to pay, also your deductible, co-insurance, co-payment or any other balance not paid by your insurance company. I authorize payment of medical benefits to Neil F. Goodman M.D. for services provided as described on my related claims. I agree to make payments in full or satisfactory arrangements at the time of service. I agree that, should this account be referred to an agency or an attorney for collection, I will be responsible for all collection fees, including attorney fees and court costs.

Patient or Responsible Party_____**Date**_____

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CONTACT LIST

Patient Name:_____

Please write the name and phone number of the person(s) you give us permission to speak with in reference to your results, questions, appointments etc. If you wish these to remain confidential please leave this page blank.

1. **Name:**_____

   Relationship: _____

   Phone Number: _____

2. **Name:**_____

   Relationship: _____

   Phone Number: _____

3. **Name:**_____

   Relationship: _____

   Phone Number: _____

☐ **I only allow medical information to be released to other doctors**

I have read and understand that I give you permission to call the above person(s) and/or leave a message.

X_____ **Date:** _____

Signature of: ☐ **Patient** ☐ **Parent** ☐ **Guardian** ☐ **Proxy**

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Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information. As a patient, you have the following rights:

1. **The right to inspect and copy your information.**
2. **The right to a summary or explanation.**
3. **The right to an electronic copy of electronic records.**
4. **The right to get a notice of a breach.**
5. **The right to request corrections to your information.**
6. **The right to a report of disclosures of your information**
7. **The right to request that your information be restricted.**
8. **The right to request confidential communications.**
9. **The right to a paper copy of this notice.**

We want to assure you that your medical/protected health information is secure with us. This notice contains information about how we will insure that your information remains private.
If you have any questions about this notice please contact the office manager, Gaby Torres at (305) 595-6855.

Acknowledgement of Notice of Privacy Practices
"I hereby acknowledge that I have received a copy of this Notice of Privacy Practices. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this Notice of Privacy practices should it be amended, modified, or changed in any way."

_____

Patient or Representative Name (Please Print) **Date**

_____

Patient or Representative Name (Signature) **Date**

☐ **Patient refused to sign** ☐ **Patient was unable to sign because:**

_____