Welcome to the office of Gary Goff, MD PA

Date: __________________

Name: _______________________________________ DOB: __________SS#: ____________

Race: ____________ Ethnicity: _______________ Preferred Language: __________________

Marital Status: _____________ Spouse's Name: ______________________ Children: _______

Address: _____________________________________ City: ___________ State/Zip: ________

PLEASE PROVIDE TWO PHONE NUMBERS AND AN EMAIL ADDRESS

Home Phone: _____________________________ Work Phone: _________________________

Cell Phone: ________________________________ Consent to Text: Yes / No

Email: _____________________________________ Consent to Email: Yes / No

Employer: ____

Insurance Carrier Name: ____

Insurance ID#: ____________________________________ Group #: _____________________

Policy Holder Name: _______________________________ DOB: ________ SS#: ___________

Policy Holder Employer: ____

Emergency Contact Name: ____

Phone #: _______________________________________ Relationship: __________________

Preferred Pharmacy: ______________________________ Phone #: ______________________

ALL PRIOR AUTHORIZATION PRESCRIPTIONS WILL BE SENT TO CEDRA PHARMACY DALLAS
9669 N CENTRAL EXPRESSWAY STE 190 DALLAS, TX 752031 T: 214-983-1000 | 214-983-1200
UNLESS OTHERWISE SPECIFIED DURING THE TIME OF YOUR VISIT OR DIRECTED BY THE PHARMACY

Prescription or OTC Medications and Dosages: _____________________________________

____

Know Drug or Food Allergies and Reactions: _______________________________________

Previous Surgeries and Dates: ____

Do you: Smoke Y / N Drink Y / N Drugs Y / N

Patient's Signature: ____ Date: ___________

Referring Physician: ______________________________ Phone #: ______________________

Welcome to the office of Gary Goff, MD PA

Consent for Treatment

I hereby authorize employees and providers of Gary Goff, MD PA to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided care.

Patient Name: ____
(Printed)

Patient Signature: ____ Date: ______________

Financial Responsibility

I hereby authorize payment of medical benefits directly to Gary Goff, MD PA for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient medical insurance company as may be necessary to process and complete the patient's medical insurance claim. I understand that I am financially responsible for the total charges for the services rendered which may include services not covered by the patient's insurance company(s). I agree that all amounts are due upon request and are payable to Gary Goff, MD PA. I further understand that if my account become delinquent, I shall pay the responsible attorney fees or collection expense of Gary Goff, MD PA, if any.

Patient Name: ____
(Printed)

Patient Signature: ____ Date: _____________

Welcome to the office of Gary Goff, MD PA

Acknowledgment of Receipt

The Health Insurance Portability and Accountability Act (HIPAA) is a federal regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. Gary Goff, MD PA is furnishing you with the attached notice, which provides information about how Gary Goff, MD PA and its physician may use and/or disclose protected health information about you for treatment,payment,health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of Gary Goff, MD PA's Notice of Health Information Practices.

Patient Name: ____
(Printed)

Patient Signature: ____ Date: _____________

Approved HIPAA Contacts

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's Billing Account, Medical Conditions to the patient or legal guardian. If you would like to add additional contacts (other than the patient or legal guardian) that Gary Goff, MD PA is allowed to disclose this type of information to, please complete the fields below.

Contact Name: _______________________________ Phone #: ________________________
Relationship: _________________________________

Contact Name: _______________________________ Phone #: ________________________
Relationship: _________________________________

Patient Name: ____
(Printed)

Patient Signature: ____ Date: _____________

Welcome to the office of Gary Goff, MD PA

New Office Policies and Procedures - Pain Medication Agreement

- Effective immediately - Pain medication prescriptions will be written for only 1 MONTH at a time with NO refills.
- Refills will only be given in an office visit evaluation.
- A Urine Screen Lab is now required before any refills will be issued – results will have to be reviewed before refill appointment can be made.
- No lost or stolen Rx's will be replaced/filled – please "guard your prescription like it were cash".
- Make sure to **take your pain medication as directed** – additional quantities will not be given if you run out before the designated timeframe.
- Must obey Dr. Goff's orders of trying other methods of pain relief as directed.
- Failure to follow this pain medication agreement results in discontinuation of all pain medications.
- This Pain Medication Agreement must be signed and agreed to each year and placed in your chart.

I HAVE RECEIVED AND READ A COPY OF THE PAIN MEDICATION AGREEMENT FOR GARY GOFF, MD PA AND I AGREE TO FOLLOW THE NEW POLICIES AND PROCEDURES.

Patient Signature: ____ Date: _____________

Welcome to the office of Gary Goff, MD PA

Notice of Privacy Practices

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the

Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to
you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.for payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are:
making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary

of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or
administrator of a deceased person’s estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this
Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause
serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained
electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

Welcome to the office of Gary Goff, MD PA

Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

Right to Request Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

Right to a Copy of this Notice. You have the right to a copy of this notice.

Welcome to the office of Gary Goff, MD PA

New Office Policies and Procedures – Insurance Prior Authorizations

- Effective immediately – Insurance Prior Authorizations will require two weeks for completion.

Please list doctors we will need to send a referral

Name: ____ DOB: __________SS#: ____________

Race: ____________ Ethnicity: _______________ Preferred Language: __________________

Marital Status: ______________ Spouse's Name: _______________________ Children: _______

Address: _______________________________________ City: ___________ State/Zip: ________

PLEASE PROVIDE TWO PHONE NUMBERS AND AN EMAIL ADDRESS

Home Phone: ______________________________ Work Phone: __________________________

Cell Phone: _________________________________ Consent to Text: Yes / No

Email: _______________________________________ Consent to Email: Yes / No

Employer: ____

Insurance Carrier Name: ____

Insurance ID#: ______________________________________ Group #: _____________________

Policy Holder Name: _________________________________ DOB: ________ SS#: ___________

Policy Holder Employer: ____

Emergency Contact Name: ____

Phone #: ____ Relationship: __________________

Preferred Pharmacy: ________________________________ Phone #: _______________________

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Prescription or OTC Medications and Dosages: ____

____

Know Drug or Food Allergies and Reactions: ____

Previous Surgeries and Dates: ____

Do you: Smoke Y / N Drink Y / N Drugs Y / N

Welcome to the office of Gary Goff, MD PA

Patient's Signature: ____ Date: ___________

Referring Physician: _______________________________ Phone #: _______________________

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