JOEL H. GOFFMAN, M.D., P.A.
8588 Katy Freeway, Suite 101, Houston, Texas 77024
Email: DENISE@EYEMDHOUSTON.COM (713) 467-0990 Fax (713) 464-6989

Dear Patient:

Thank you for entrusting us with the most valuable of your five senses—your eyes. Please read the entire letter and adhere to the following instructions.

COVID-19 Protocol

-Patients and staff must wear a mask covering nose and mouth

-Social distancing requirements will be observed

-Contactless check in and check out when possible

-Extended appointment times with minimum patient interaction

-Emailing/faxing forms, insurance cards and photo ID minimalizing contact

Patient forms will be emailed or mailed to you for your completion. Fillable forms may be completed and saved to your computer and then emailed to our secure, HIPPA compliant email address: Denise@eyemdhouston.com . You may print and bring them with you to your appointment as well. All forms should be completed inlcuding signatures. Most PDF readers will allow you to place a signature into a PDF.

Insurance card(s) should be faxed or emailed to us at least 7 days prior to your appointment.This ensures that your insurance benefits and in-network status can be verified in advance. **If you would like an estimate of your charges, feel free to contact us**. If you have a separate vision plan, please verify with your plan that we are a participating provider prior to your visit. We now offer HIPPA compliant email if you would prefer to email to **Denise@eyemdhouston.com**.

Medicare Patients: Effective January 2020, Medicare will only process claims with the new 11 digit Beneficiary number. If you do not provide the office with this information 1 week prior to your appointment, we will be unable to file a claim for your services and you will be responsible for the full cost of the services received. Please send copies of both your Medicare and secondary/supplemental insurance cards. *If your plan requires a referral to a specialist, your primary care physician must fax the referral to our office prior to your appointment*.

Please arrive at your appointment time to ensure that you are seen promptly. Bring your insurance cards and photo ID to every appointment, in addition to your eyeglasses and contact lenses.Please allow 2 hours for your examination. ***Please turn off or silence your cell phone when you arrive***.

Cancellation Policy: Please call us at 713-467-0990 by 2:00 p.m. 2 days prior to your scheduled appointment to notify us of any changes or cancellations. To reschedule and/or cancel a Monday appointment, please call our office by 2:00 p.m. on Thursday. If prior notification is not given, you will be charged $25 for the missed appointment.

Your cooperation in these matters is greatly appreciated. We look forward to seeing you!

Remember to Bring

1. **All Insurance Card(s) &Photo ID (required by insurance) if not emailed to office**
2. **Facial Mask**
3. **Pen to Complete forms if not emailed to office**
4. **Patient Forms if not emailed to office (Denise@eyemdhouston.com)**
5. **Current Medication List**
6. **Eyeglasses & Contact Lenses (wear to appointment)**
7. **New Patient - Bring your contact lens Rx or your boxes.**
8. **Pharmacy Information**
9. **Dr’s Name and Fax # (Diabetic and Plaquenil Pts.)**

*****After completing the entire form, click File, then Save As, click Desktop, Save Go to your email and send document as an attachment.**

Joel Goffman, M.D.,P.A.
8588 Katy Freeway, Suite 101
Houston, Texas 77024
713-467-0990

Take Bingle/Voss exit off of I-10.
Coming from the east (Katy, Texas), turn left under the freeway.
Coming from the west (downtown), turn right on Bingle.
At the first traffic light, turn right on West Memorial Park Drive.
You will see a large red sign: West Memorial Park Office Park.
Turn left into the parking lot after the first speed bump.
Visitor and handicap parking available on ground level and parking garage.

Visitor Parking
Visitor Parking Garage
Dr. Goffman's Office
Visitor Parking
Visitor Parking
8588 Suite 101
8584
Visitor Parking
Bingle Road
W. Memorial Park
Speed Bump
Katy
I-10 Katy Freeway
Downtown
Voss Road

Wellness Form

Patient Name: Date:

Phone:

Email:

1. Do you have a cough?

2. Do you have a fever now or have you in the past 14-21 days?

3. Have you come in contact with any confirmed COVID-19 positive

4. Are you experiencing shortness of breath or difficulty breathing?

5. Are you experiencing other flu-like symptoms, such as gastrointestinal upset, headache, fatigue?

6. Have you experienced recent loss of taste or smell?

7. Are you over the age of 60?

8. Do you have heart disease, lung disease, kidney disease, diabetes, or aother auto-immuno disorders?

9. Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)

If you answered “YES” to questions 1-6 or 9, please call the office an reschedule your appointment and contact your doctor. Thank you!

2020- PATIENT INFORMATION: (PLEASE PRINT CLEARLY)

WHO SHOULD WE THANK FOR REFERRING YOU TO OUR OFFICE?

PATIENT FULL NAME: **AGE:**

MARTIAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

GENDER: MALE FEMALE STUDENT: YES NO

ADDRESS:

CITY: STATE: ZIP:

EMPLOYED BY: OCCUPATION:

PREFERRED COMMUNICATION: I AUTHORIZE THE USE OF THE FOLLOWING FORMS OF COMMUNICATION. We will contact you by phone, voicemail, text or email for the following: appointment reminders, recalls and confirmations; orders ready for pickup; statements; surgery instructions and any other patient information.

CELL PHONE: TEXTING: YES NO

HOME/WORK PHONE: LEAVE MESSAGE: YES NO

EMAIL: YES NO

WHOSE NAME IS THE INSURANCE UNDER? RELATIONSHIP TO PATIENT?:

NAME: SELF SPOUSE PARENT GUARDIAN

SAME BILLING ADDRESS: YES NO EMPLOYER:

EMPLOYEE/PRIMARY INSURED'S DATE OF BIRTH: SS#:

If different from patient:

PRIMARY MEDICAL INSURANCE :

SECONDARY INSURANCE:

VISION INSURANCE:

PATIENT 'S DATE OF BIRTH: PATIENT SS#:

PATIENT'S DRIVER'S LICENSE: EXPIRES: STATE:

DIABETIC DR'S NAME: FAX #:

PHARMACY NAME: PHONE:

INFORMATION REGARDING DILATING EYE DROPS

Dilation is a procedure which allows the doctor to use eye drops to temporarily enlarge your pupils for a more extensive view of the retina (back of the eye). like looking into a room through an open door instead of a keyhole. With dilation, the doctor can evaluate and diagnosis eye health problems before symptoms occur. Examples include Diabetes, Cataracts, Glaucoma, Retinal Detachment, Macular Degeneration, High Blood Pressure, Cancer, etc.

Dilation is an important part of a complete eye exam. It is recommended that all patients receive a comprehensive dilated examination every year.

Some patients may experience blurred vision up close and light sensitivity for 2-6 hours. In most cases, distance vision will be minimally affected. If you do not have a pair of dark sunglasses for your ride home, we will provide you with a disposable pair. Typically, you will be able to drive following your exam; however, if you feel more comfortable being driven, please make arrangements ahead of time. You should not operate heavy equipment or drive an automobile unless you are comfortable with your vision. Please note there is no additional charge for having your eyes dilated.

It is not possible for Dr. Goffman to predict how much your vision will be affected.

I hereby authorize Dr. Goffman and/or such assistants, as may be designated by him, to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patient Signature (or person authorized to sign for patient) DATE

OFFICE POLICY

Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please do not hesitate to contact the staff. We do not guarantee the accuracy of benefit information given to us by your insurance company. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits to Joel H. Goffman, M.D., P.A..

I understand that I am responsible for any balance my insurance does not cover or pay.

Patients are responsible for payment at the time of service. An estimate of your out-of-pocket expenses will be given to your prior to your appointment. **You are responsible for any unmet deductible, coinsurance or copays, and any non-covered services at the time services are rendered**.

- **I have received the Notice of Privacy Practices and been provided an opportunity to review it.**
- ***Cancellation of an appointment less than 48 hours prior will result in a $25., No Show fee.***
- ***An administration fee of 5% will be applied to all cancelled medical procedures and services***
- ***A restocking fee of 15% and administrative fee of 5% will be applied to all cancelled orders and/or returns.***

Signed:____ Date:___________________________________

MEDICAL INFORMATION SHEET (PLEASE EMAIL TO DENISE@EYEMDHOUSTON.COM)

PATIENT NAME:

PLEASE INDICATE ALL THAT APPLY. IF YOU DO NOT INDICATE AN ITEM, YOU DENY CURRENTLY HAVING OR HAD ANY OF THE SYMPTOMS OR CONDITIONS LISTED BELOW. IF YOUR CONDITION IS NOT LISTED PLEASE INDICATED IT IN THE SPACE PROVIDED. FAILURE TO LIST A MEDICAL CONDIITION OR PROCEDURE COULD EFFECT YOUR TREATMENT.

MEDICAL & EYE HISTORY: DO YOU HAVE OR HAD ANY OF THE FOLLOWING CONDITIONS? NONE

A-FIB	DIABETES	HEADACHES	MOTION SICKNESS
ALZHEIMER'S	DIZZINESS	HERPES	PTERYGIUM
ARTHRITIS	FEVER BLISTERS	HIGH BLOOD PRES.	SJORGEN'S
ASTHMA	FLASHES	KERATOCONUS	STROKE
BLEPHARITIS	FLOATERS	KIDNEY DISEASE	THYROID
CATARACTS	FUCH'S DYSTROPHY	LUPUS	RHEUMATOID ARTHRITIS
COLD SORES	GLAUCOMA	MIGRAINES	
CORNEAL DYSTROPHY	MYOCARDIAL INFARCTION	MACULAR DEGENERATION	LATTICE DEGENERATION

LIST ANY OTHER MEDICAL CONDITIONS NOT LISTED ABOVE:

SURGICAL HISTORY: PLEASE INDICATE ANY PROCEDURE YOU HAVE HAD: NONE

CATARACT	AFTER CATARACT LASER	EYELID	PRK
EYE MUSCLE	RETINAL	GLAUCOMA	RK
HEART	STENTS		LASIK

LIST ANY OTHER PROCEDURES NOT LISTED ABOVE:

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES

SOCIAL HISTORY: TOBACCO YES NO ALCHOOL YES NO

MEDICATIONS: NONE

RX OR OTC	MEDICATIONS	STRENGTH	DOSAGE	PURPOSE - WHY DO YOU TAKE THIS MEDICATION?

SEE ATTACHED MEDICATION LIST

FAMILY HISTORY: UNKNOWN ADOPTED

CATARACTS	MACULAR DEGENERATION	DIABETES	GLAUCOMA
HIGH BLOOD PRESSURE			

REVIEW OF SYSTEMS– CURRENT MEDICAL CONDITIONS: Please indicate your present/current medical conditions below.

SKIN: itching, rash, ulcer tumors(growths), other	YES	NO
LYMPH NODES: swelling, tenderness, other	YES	NO
BONES, JOINTS: MUSCLES: muscle pain/cramps, joint pain, swelling, other	YES	NO
ENDOCRINE (e.g. Thyroid): fatigue, confusion, fainting, nervousness, hot/cold intolerance/hair loss, other	YES	NO
ALLERGY/IMMUNOLOGY: recurrent infections, hay fever, hives, food allergy, drug sensitivity, other	YES	NO
HEAD: headaches, migraines, dizziness, vertigo, other	YES	NO
EARS: hearing loss, ringing, infections, other	YES	NO
NOSE: bleeding, loss of smell, congestion, sinus problems, other	YES	NO
THROAT: dry mouth, loss of taste, difficulty swallowing, hoarseness, other	YES	NO
NECK: pain, swelling, stiffness, other	YES	NO
BREASTS: tenderness, swelling, lumps, discharge, other	YES	NO
BLOOD: bruise easily, prolonged bleeding, skin hemorrhages, blood loss, other	YES	NO
RESPIRATORY: wheezing, cough (productive/blood), difficulty breathing, asthma, other	YES	NO
CARDIOVASCULAR (heart/blood vessels): chest pain, swelling in extremities, shortness of breath, **exercise intolerance, other**	YES	NO
GASTROINSTESTINAL (stomach/intestines): nausea, vomiting, change in bowel habits, constipation, **diarrhea, pain/cramps, bleeding, other**	YES	NO
GENITOURNIARY (kidney/bladder): frequency, burning, hesitancy, pain or bleeding on urination, **infections, incontinence, impotence, other**	YES	NO
NERVOUS SYSTEM: weakness in arms or legs, numbness or tingling, loss of consciousness, falls, difficulty **walking, seizures, tremors, neuralgia, memory loss, confusion, other**	YES	NO
PSYCHIATRIC: disorientation, mood swings, anxiety, depression, hallucinations, other	YES	NO

Please any other conditions you currently have that are not listed above ____________________

To the best of my knowledge, the questions on this form have been **answered completely and accurately**. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Dr. Goffman of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient or Responsible Party Date

Printed Patient Name

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION
JOEL H. GOFFMAN, M.D.
HIPAA Compliance Officer - JOEL H. GOFFMAN, M.D.

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name of Patient (print): ______________________________________ Date of Birth: _____________________

I. My Authorization
I authorize the following using or disclosing party: JOEL H GOFFMAN MD PA to use or disclose the following health information.

[ ] All of my health information
[ ] Other: ____

The above party may disclose this health information to the following recipient:

Name/Organization: ____
*Relationship to patient:*____
We will not release information regarding medical conditions, financial obligations, appointments and any other information regarding our patient unless the patient indicates in the above section.

The purpose of this authorization is (check all that apply):
[ ] At my request
[ ] Other:____

This authorization ends:
[ ] On (Date): _________________________
[ ] When I am no longer a patient of JOEL H GOFFMAN MD PA

II. My Rights
I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: ______________________________________ Date: ______________________________

If the patient is a minor or unable to sign above please complete the following:
[ ] Patient is a minor: _______ years of age
[ ] Patient is unable to sign because:_________________________________

Signature of Authorized Representative: ___________________________________Date: __________________

Print Name of Authorized Representative:____

Authority of representative to sign on behalf of patient:[ ] Parent [ ] Legal Guardian [ ] Court Order

[ ] Other: ____

Notice of Privacy Practices

Effective 2019

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human, Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

Do research

We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Patient Name: ____

Patient Signature: ____

Date: ______________________