STATE OF INDIANA
ONLINE RENEWAL RECORD

Renewal Submission Date:	September 20, 2019

Person Info

Name:	Sarah Beth Gopman
License Number:	01082088A

Address Info

Street Address:	
	6450 Around the Hills Rd
City:	Indianapolis
State:	IN
Zipcode:	46226
County:	Marion
Phone:	
Email:	

Question Response Summary

1.) Since you last renewed, has any health profession license, certificate, registration or permit you hold or have held been disciplined or are formal charges pending in any state or U.S. territory?	N
2.) Since you last renewed, have you been denied a license, certificate, registration, or permit in any state or U.S. territory?	N
3.) Since you last renewed, and except for minor violations of traffic laws resulting in fines and arrests or convictions that have been expunged by a court, have you been arrested, entered into a diversion agreement, been convicted of, pled guilty to, or pled nolo contendere to any offense, misdemeanor, or felony in any state or U.S. territory?	N
4.) Since you last renewed, have you had a malpractice judgment against you or settled any malpractice action?	N
5.) Since you last renewed, have you been denied staff memberships or privileges in any hospital or clinic or have staff membership or privileges been revoked, suspended, or subjected to any restriction, probation, or other type of discipline or limitations?	N
6.) Since you last renewed, have you been excluded from being a Medicare or Medicaid provider?	N
7.) Since you last renewed, have you surrendered your DEA registration at any time or had any limitations or discipline placed on your DEA registration?	N
Citizenship Status: You should only indicate one 'Yes' response to the statement below.	
Pursuant to IC 12-32-15 and IC 12-32-1-6, I swear under the penalty of perjury that:	
I am a United States Citizen	Y
I am a Qualified Alien as defined under 8 U.S.C. 1641	N

Survey Response Summary

01.) What is your employment status?	Actively working in a position that requires a medical license
02.) What is your race? Mark one or more boxes.	White
03.) Are you Hispanic or Latino origin?	N
04.) Where did you complete your medical degree?	Another State (not listed)
05.) Where did you complete your residency training?	Another State (not listed)
06.) Which of the following best describes the area of practice in which you spend most of your professional time? Please select only one response.	Family Medicine/General Practice
07.) Do you use telemedicine to deliver services to patients located in Indiana (as defined in IC 25-1-9.5-6; the delivery of health care services using electronic communications and information technology, including: secure videoconferencing, interactive audio-using store and forward technology, or remote patient monitoring technology between a provider in one (1) location and a patient in another location)?	N
08.) What is the street address of your primary practice location (for telemedicine providers: where the patient is located)? If this does not apply, please indicate "N/A"	1434 Shelby St
09.) In what city is your primary practice location? If this does not apply, please indicate "N/A"	Indianapolis
10.) In what state is your primary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A"	IN
11.) What is the 5-digit ZIP code of your primary practice location? If this does not apply, please indicate "N/A"	46203
12.) Which of the following categories best describes the practice setting at your primary practice location? If this does not apply, please select "not applicable."	Office/Clinic – Multi Specialty Group
13.) Estimate the average number of hours per week spent in direct patient care at your primary practice location. If this does not apply, please select "not applicable."	25 – 28 hours per week
14.) Estimate the percentage of Indiana Medicaid patients at your primary practice location. If this does not apply, please select "not applicable."	Indiana Medicaid accounts for greater than 50% of my practice
15.) Are you accepting new Indiana Medicaid patients at any or all of your practice locations?	Y

16.) If you selected no on the previous question, but you are enrolled as an Indiana Medicaid provider, please describe barriers to participation. If this does not apply, please indicate "N/A".	N/A
17.) Estimate the percentage of patients on a sliding fee scale at your primary practice location. If this does not apply, please select "not applicable."	Sliding fee patients account for 11% - 20% of my practice
18.) What is the street address of your secondary practice location (for telemedicine providers: where the patient is located)? If this does not apply, please indicate "N/A".	N/A
19.) In what city is your secondary practice location? If this does not apply, please indicate "N/A".	N/A
20.) In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A".	N/A
21.) What is the 5-digit ZIP code of your secondary practice location? If this does not apply, please indicate "N/A".	N/A
22.) Which of the following categories best describes the practice setting at your secondary practice location? If this does not apply, please select "not applicable."	Not applicable
23.) Estimate the average number of hours per week spent in direct patient care at your secondary practice location. If this does not apply, please select "not applicable."	Not applicable
24.) Estimate the percentage of Indiana Medicaid patients at your secondary practice location. If this does not apply, please select "not applicable."	Not applicable
25.) Estimate the percentage of patients on a sliding fee scale at your secondary practice location. If this does not apply, please select "not applicable."	Not applicable
26.) What is the street address of your tertiary practice location (for telemedicine providers: where the patient is located)? If this does not apply, please indicate "N/A".	N/A
27.) In what city is your tertiary practice location? If this does not apply, please indicate "N/A".	N/A
28.) In what state is your tertiary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A".	N/A
29.) What is the 5-digit ZIP code of your tertiary practice location? If this does not apply, please indicate "N/A".	N/A
30.) Which of the following categories best describes the practice setting at your tertiary practice location? If this does not apply, please select "not applicable."	Not applicable
31.) Estimate the average number of hours per week spent in direct patient care at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
32.) Estimate the percentage of Indiana Medicaid patients at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
33.) Estimate the percentage of patients on a sliding fee scale at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
34.) Please indicate which of the following services you routinely provide as a part of your practice: (Note: The purposes of this services list is to gather information on key health issues in Indiana) Please check all that apply.	Addiction counseling ,MAT (Medication Assisted Treatment) - Buprenorphine,Post-natal services,Pre-natal services,Screening for addiction (ex: SBIRT),Treatment of OUD-affected Pregnant Women
35.) Please indicate the population groups to which you provide services:	Newborns,Children (ages 2-10),Adolescents (ages 10-19),Adults,Geriatrics (Ages 65+),Pregnant women,Disabled Individuals,Individuals in recovery