

## **WELCOME TO DELMAR MEDICAL CENTER, P.A.**

Thank you for choosing DELMAR MEDICAL CENTER, P.A. as your medical home. We appreciate your confidence in our practice and will do our best to attend to your primary healthcare needs.

In order to become established in our practice, we will need to learn about your medical history, review your past medical records, and obtain general demographic and insurance information.

This Welcome Packet includes:

- Medical History Form and Medication List
- Notice of Privacy Policies and Practices
- Authorization of Use and Disclosure of Protected Health Information
- Office Policy Form

Please take time to read and complete these forms carefully. As soon as you return the forms to us, we will schedule your appointment with the doctor for your initial visit and examination.

We require at least a 24-hour notice if you are unable to keep your appointment. Please note that if you miss your initial appointment, we will not be able to reschedule.

Our mission at DELMAR MEDICAL CENTER, P.A. is to help our patients with their health problems and concerns to the best of our ability.

We hope that we will achieve this objective to your full satisfaction. Please let us know if you have any questions or concerns.

***WE CARE ABOUT YOUR HEALTH!***

**AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

<b>Print Name</b>	<b>Social Security Number</b>	<b>Birth Date</b>
<b>Address</b>	<b>City</b> <b>State</b>	<b>Zip Code</b>
<b>Home Phone</b>	<b>Employer Name</b>	<b>Work or Mobile Phone</b>

**APPOINTMENT REMINDERS**

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at DelMar Medical Center, P.A.? (check all that apply)

**Home Phone** [ ]    **Mobile Phone** [ ]    **Work Phone** [ ]    **E-mail** [ ] \_\_\_\_\_

If you have an **answering machine**, may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at DelMar Medical Center, P.A.? \_\_\_\_\_

**PERSONS/ORGANIZATIONS AUTHORIZED TO RECEIVE INFORMATION**

I authorize the person(s)/organization(s) listed below to receive information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at DelMar Medical Center, P.A.:

<b>Name of the person/organization</b>	<b>Relation</b>	<b>Phone Number(s)</b>
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**Right to Restrictions.** You have the right to request restrictions on use and disclosure of your health information. I would like the following **restrictions regarding the use and disclosure** of my health information:

\_\_\_\_\_

\_\_\_\_\_

**Potential for Re-Disclosure.** The person(s) or organization(s) to which health information is released may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

**Right to Terminate or Revoke Authorization.** If you change your mind after authorizing a use or disclosure of your information, you may revoke or terminate this authorization by submitting a written revocation to DelMar Medical Center, P.A. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

**OTHER USES AND DISCLOSURES**

Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Policies and Practices" requires your specific written authorization.

**PLEASE SIGN BELOW TO ATTEST THAT YOU HAVE RECEIVED AND CAREFULLY READ THE "NOTICE OF PRIVACY POLICIES AND PRACTICES" AND HAVE UNDERSTOOD ITS CONTENT FULLY, AND THAT YOU AGREE AND ACCEPT ITS TERMS, AND WILL ABIDE BY ITS REGULATIONS.**

**PLEASE SIGN BELOW TO AUTHORIZE AND DIRECT PAYMENT TO DelMar Medical Center, P.A. FOR THE MEDICAL AND/OR SURGICAL BENEFITS PAYABLE UNDER THE TERMS OF YOUR HEALTH INSURANCE.**

<b>Patient/Representative Signature</b>	<b>Print Name</b>	<b>Date</b>
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**MEDICAL HISTORY FORM**

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Have YOU had? (Please circle each answer):**

- 1. High blood pressure Y N
- 2. Heart problems Y N
  - a) MI/Heart attack Y N
  - b) Angina chest pain on exertion Y N
- 3. Shortness of breath Y N
- 4. Asthma, Emphysema Y N
- 5. Tuberculosis, Asbestosis, other lung disease Y N
- 6. Stomach pains Y N
- 7. Change in stools Y N
  - a) constipation/diarrhea Y N
  - b) bloody/tarry stools Y N
- 8. Hepatitis, liver, pancreas disease Y N
- 9. Burning/stinging on urination Y N
- 10. Urgency/difficulty controlling urine Y N
- 11. Frequent urination at night Y N
- 12. Diabetes Y N
- 13. Thyroid problems Y N
- 14. Arthritis, joint pain Y N
- 15. Back pain Y N
- 16. Vascular/circulation problems Y N
  - a) leg swelling Y N
  - b) phlebitis, blood clots Y N
  - c) leg pain on exertion Y N
- 17. Anemia, other blood disorder Y N
- 18. Abnormal bleeding Y N
- 19. Seizure disorder/fainting Y N
- 20. Depression/anxiety Y N
- 21. Stroke Y N
  - a) any symptoms/weakness from the stroke? Y N
- 22. Recent weight loss Y N
- 23. Recent weight gain Y N
- 24. Are you on a special diet? Y N
- 25. Cancer/Personal history of cancer Y N
- 26. Allergies to drugs Y N
- 27. Other allergies Y N
- 28. Breast lumps/nodules Y N
- 29. Abnormal vaginal bleeding (female) Y N
- 30. Other problems Y N

If you answered "Yes" please provide more **details** here:

- # \_\_\_\_\_
- # \_\_\_\_\_
- # \_\_\_\_\_
- # \_\_\_\_\_
- # \_\_\_\_\_

List any **FAMILY history** of the above problems:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Occupation: \_\_\_\_\_

Single [ ] Married [ ] Divorced [ ] Widowed [ ]

**Previous hospitalizations, surgeries, biopsies, and endoscopies** (give date and reason):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Hospital preference: \_\_\_\_\_

- 1. Any abnormal reactions to anesthesia: Y N
- 2. Have you had blood transfusions? Y N
- 3. Would you agree to a blood transfusion if necessary? Y N
- 4. Do you smoke cigarettes? Y N
- 5. Do you drink alcohol? Y N
- 6. Do you use drugs? Y N

**Female:** 7. Are you pregnant? Y N

8. Are you planning pregnancy? Y N

9. Day of last menstrual period: \_\_\_\_\_

**Immunizations:**

- 10. Flu vaccine Y N
- 11. Pneumonia vaccine Y N
- 12. Tetanus vaccine within 10 years Y N
- 13. Hepatitis vaccine Y N
- 14. Lyme vaccine Y N
- 15. Measles/Mumps/Rubella vaccine Y N
- 16. Shingles (zoster) vaccine Y N

If you answered "Yes", please provide more details here:

- # \_\_\_\_\_
- # \_\_\_\_\_
- # \_\_\_\_\_
- # \_\_\_\_\_

Sign here: \_\_\_\_\_ Date: \_\_\_\_\_



**OFFICE POLICIES**

Our mission at the DelMar Medical Center, PA is to help our patients with their health problems and concerns to the best of our ability. Thank you for your consideration of the following office policies:

- All visits are by appointment only. In fairness to all our patients, we cannot serve walk-ins.
- Please call at least 24 hours in advance to cancel or reschedule your appointment. A “NO-SHOW” fee of \$25.00 may be assessed for missed appointments.
- It is your responsibility to know when your next scheduled office visit is. Reminder cards and calls are provided as a courtesy.
- Patients who repeatedly miss or cancel appointments may be subject to release from the practice.
- Please be on time for your appointment. If you are late, your appointment may need to be rescheduled.
- Please do not bring children to your appointment. We love children, but because of limited space in the waiting area, consideration for other patients, concern for your child’s safety, and distraction during the visit, your appointment may be rescheduled.
- It is your responsibility to promptly report any change in your insurance, address, or telephone number(s). If the insurance information is outdated or incorrect you may be charged a \$25 fee for reprocessing of the insurance claim(s).
- Please present your current insurance card(s) at every appointment. If you do not have your current insurance card(s) with you, your appointment may be rescheduled.
- All insurance co-pays are due at the time of visit and must be paid before being seen by the physician.
- Patients with no insurance or with an insurance that we do not have a signed contract with must pay the full amount at the time of visit.
- There is a \$25 fee for all returned checks. Any future payments will be accepted in cash only.
- Patients who fail to pay their account balance in a timely fashion may be subject to release from the practice. Please remit your payment upon receipt of the statement.
- Please submit all your billing inquires in writing to DelMar Medical Center, 1350 Middleford Rd, Suite 501, Seaford, DE 19973.
- Please request referrals and prior authorizations at least 48 hours in advance; otherwise your appointment may be rescheduled.
- There may be a fee assessed for services which are not directly related to your office visit, such as copying records, filling out forms, faxing or mailing documents, etc.
- Please request your prescription refills at least 24 hours in advance. You should never wait until you run out of your medication.
- If you need to reach the doctor during normal business hours, please call the office. In a true emergency, it is best to call 911 or proceed to the emergency department of the nearest hospital.

I have read and understand the policies of the practice. I understand that this document is not intended to form a contract. I also understand that these policies may be amended at the discretion of the practice.

Patient acknowledgement: \_\_\_\_\_  
*signature* *print name*

Date: \_\_\_\_\_

## **DelMar Medical Center, P.A.**

### **NOTICE OF PRIVACY POLICIES AND PRACTICES**

#### **DEAR PATIENT,**

**THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

#### **INTRODUCTION**

At DelMar Medical Center, P.A. we are committed to treating and using protected health information about you responsibly. This notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

#### **UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION**

Each time you visit DelMar Medical Center, P.A. a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as:

- basis for planning your care and treatment
- means of communication with other health professionals involved in your care
- legal document outlining and describing the care you received
- a tool that you, or another payer (your insurance company) will use to verify that services billed were actually provided
- an education tool for medical health providers
- a source for medical research
- basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards
- a source of data for planning and/or marketing
- a tool that we can reference to ensure the highest quality of care and patient satisfaction

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

#### **YOUR RIGHTS**

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected healthcare information has been disclosed
- the right to receive a printed copy of this notice

#### **OUR RESPONSIBILITIES**

DelMar Medical Center, P.A. is required to:

- maintain the privacy of your health information
- provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have regarding communication of health information via alternative means

## NOTICE OF PRIVACY POLICIES AND PRACTICES

*(continued)*

### REVISIONS AND AMENDMENTS

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to procedures included in the authorization.

### HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

**We will use your health information for treatment.** Your health information may be used by staff members or disclosed to other health care professionals for evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**We will use your information for payment.** Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.

**We will use your information for regular health operations.** Your health information may be used as necessary to support the day-to-day activities and management of DelMar Medical Center, P.A. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**Business Associates.** In some instances, we have contracted separate entities to provide services for us. These “associates” require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these “business associates” might be a billing service, collection agency, answering services, and computer software/hardware provider.

**Communication with family.** Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, or other relatives, or any other person that is involved in your care or that you have authorized to receive this information. Please inform the practice when you do not wish a family member or other individual to have authorization to receive your information.

**Research/Teaching/Training.** We may use your information for the purpose of research, teaching, and training.

**Public health reporting.** Your health information may be disclosed to public health agencies as required by law.

**Law enforcement.** Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

**Appointment reminders.** The practice may use your information to remind you about upcoming appointments. Typically, a brief non-specific message will be left on your answering machine. If you do not approve of this method, or, if you prefer alternative methods please inform the practice.

**Other uses and disclosures.** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

### FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or the privacy practices of DelMar Medical Center, P.A. please contact your physician or mail your questions to our address on your card.

If you believe that your privacy rights have been violated, please contact the aforementioned practice privacy official or, you may file a complaint with the office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint either with the practice’s privacy official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509 F, HHH Building

Washington, DC 20201