Middletown Family Care Assoc., LLC

Proudly serving Middletown and the surrounding community since 1996.

www.MiddletownFamilyCare.com

Ketlay Plaza

114 Sandhill Dr., Suite 101
Middletown, DE 19709

Tel. 302.378.4779
Fax 302.378.4789

OFFICE HOURS
We have extended hours!

Monday - Thursday: 8:30am-6:30pm

Friday: 8:00am-4:30pm

Our on-call providers are available after hours.

Call (302) 378-4779

Ask us about how to stay on top of your health through IQHealth's secured Patient Portal.

We WELCOME YOU to our practice!

We respect your time and we would like to make your visit to our office as efficient as possible.

We are pleased to tell you that our office is located in an area easily accessible by car or bus. We also have ample parking space. Should you need directions, please call us ahead of time.

REMINDERS:

1) **CANCELLATIONS / NO SHOW**: please call us at least 24 hours before your appointment to avoid a $30 no show fee.
2) **ON YOUR VISIT**:
    1. Please plan to arrive at least 15 minutes prior to your scheduled appointment.
    2. In order for us to expedite your registration process, **please bring the following items with you**:
        - ***Patient Registration*** *Form, completely filled-out and signed*
        - ***Medical History*** *Form, completely filled-out and signed*
        - ***Consent*** *Form, completely filled-out and signed*
        - *List of **all your current medications***
        - *Valid **insurance card**(s)*
        - ***Photo ID**, preferably state issued*
        - ***Co-pay**, if it applies to your insurance*

    ***** Please be aware that if you fail to bring the above items with you, we will have to ask you to reschedule*** (office forms excluded, the office can provide if you are unable to print the new patient packet online).

3) **Don't forget visit www.middletownfamilycare.com** for information about Patient-Centered Medical Home.

Enclosed you will find important documents about our practice.
To better serve you, please review and complete the documents carefully.

Please do not hesitate to call us if you have any questions.

Thank you for choosing us as your primary care provider!

We look forward to meeting with you soon!

DEMOGRAPHIC INFORMATION

Today's Date	First Name		Last Name	MI	Gender
Date of Birth	Age	Social Security # (Last 4 Digits)	Occupation	Marital Status	
Street Address			City, State	Zip Code	
Cell Phone #		Home Phone #		Work Phone #	
Email Address					

EMERGENCY CONTACT

Name:		Relation to Patient
Home Phone #	Cell Phone #	Work Phone #

PHARMACY

Name:	Main Phone #	Location #

INSURANCE INFORMATION

COPY OF INSURANCE CARD & PHOTO ID

If your insurance coverage is under another person's name, please note their name and date of birth:

Name of Policy Holder	**Date of Birth**

RESPONSIBLE PARTY

Last Name			First Name	MI	Gender
Date of Birth	Age	Social Security #(Last 4 Digits)	Occupation	Marital Status	
Street Address			City, State	Zip Code	
Cell Phone #		Home Phone #		Work Phone #	
Email Address					

Please initial and sign at the bottom:

_____ **Authorization and Assignment of Benefits:** I hereby give permission to Middletown Family Care Assoc., LLC and its employees, agents, and medical providers to release medical information to health plans, health organizations, governmental agencies, and other entities charged with fiscal responsibility for the payment of medical services rendered to me. I hereby authorize payment of the medical benefits otherwise payable to me to be directed to Middletown Family Care Assoc., LLC. I consent to have any monies received by the provider of services on my behalf to be applied to my outstanding accounts. I assume full responsibility for payment of any charges for the medical services provided. I understand that any or all of my medical information may be electronically submitted to any or all treating providers, hospitals, and/or health care entities. I permit a copy of this authorization to be used in place of the original.

_____ **Financial Policy Acknowledgement:** I hereby acknowledge that I have received and reviewed the FINANCIAL POLICY of Middletown Family Care Assoc., LLC. I understand that it is my responsibility to provide Middletown Family Care Assoc., LLC with my current demographic, insurance, and medical information.

_____ **HIPAA Privacy Acknowledgement:** I hereby acknowledge that I have received and reviewed the NOTICE OF THE PRIVACY PRACTICES from Middletown Family Care Assoc., LLC.

Patient or Guardian Signature:_____ **Relationship:** _____ **Date:** _____

Patient Consent for Use and Disclosure of Protected Health Information (HIPAA)

The individual whose signature appears below hereby attests to the following statements:

With my consent, MIDDLETOWN FAMILY CARE ASSOCIATES, LLC, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Please refer to MIDDLETOWN FAMILY CARE ASSOC., LLC'S Notice of Privacy Practices for a more complete description of such uses and disclosures.)

With my consent, MIDDLETOWN FAMILY CARE ASSOC., LLC may disclose my PHI to the following individuals (family, relatives, or friends) who may assist in my care:

Name	Relationship	Cell #:	Home #:	Work #:

Please indicate name, contact numbers, and relationship of individuals to whom MIDDLETOWN FAMILY CARE ASSOC., LLC may release PHI.

I have the right to review the Notice of Privacy Practices prior to signing this consent. MIDDLETOWN FAMILY CARE ASSOC., LLC reserves the right to revise its Notice of Privacy Practices at anytime. A written copy of our Notice of Privacy Practices may be obtained by forwarding a written request to our office.

CONSENT FOR CALLS TO HOME
With my consent, MIDDLETOWN FAMILY CARE ASSOC., LLC may call my home or other designated location and leave message on my voice mail or with a person in reference to any item that may assist MIDDLETOWN FAMILY CARE ASSOC., LLC in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

CONSENT FOR MAIL
With my consent, MIDDLETOWN FAMILY CARE ASSOC., LLC may mail to my home or other designated location any item that may assist MIDDLETOWN FAMILY CARE ASSOC., LLC in carrying out TPO such as appointment reminder cards and patient statement as long as they are marked CONFIDENTIAL.

CONSENT FOR E-MAIL
With my consent, MIDDLETOWN FAMILY CARE ASSOC., LLC may e-mail to my designated e-mail address any message in reference to any item that may assist in my care.

MIDDLETOWN FAMILY CARE ASSOC., LLC may contact me for TPO use, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

I have the right to request that MIDDLETOWN FAMILY CARE ASSOC., LLC restricts how it uses or discloses my PHI to carry out the TPO, However, MIDDLETOWN FAMILY CARE ASSOC., LLC is not required to agree to my requested restrictions, but, if it does, it is bound by this agreement.

By signing this form, I am consenting to MIDDLETOWN FAMILY CARE ASSOC., LLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that MIDDLETOWN FAMILY CARE ASSOC., LLC has already made disclosure in reliance upon my prior consent. If I do not sign this consent, MIDDLETOWN FAMILY CARE ASSOC., LLC may decline to provide services to me.

Signed by: _____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Patient's Name — Date

_____
Printed Name of Patient or Legal Guardian

(PATIENT/GUARDIAN WILL BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION)

Patient Medical History Form

Patient Name: _____ **Date of Birth**: _____/_____/_____

To help the doctor serve you better, please complete the information below. Thank you!

Allergies: □ No known Allergies (If yes, please list all Drug, Food, and Environmental Allergies below:)

_____

_____

Medications: Preferred Pharmacy: _____ Location: _____

Please list all current Over the Counter and Prescribed Medications with their corresponding dosages: (if known)

NAME OF MEDICATION	STRENGTH	HOW OFTEN?	MONTH/YR STARTED

Personal Medical History: Did you in the **Past**, or do you **Currently** have problems with any of the following?
(Please check all that apply to YOU)

CONDITION	PAST	CURRENT	DATE/ AGE ONSET:	DATE/AGE RESOLVED:
ABDOMINAL PAIN- CHRONIC				
AGITATION				
ALCOHOL ABUSE/ ADDICTION				
ALLERGIES				
ANEMIA				
ARTHRITIS				
ASTHMA				
BACK PAIN-RECURRENT				
BLEEDING EASILY				
BLOOD IN URINE/HEMATURIA				
BLOODY OR TARRY STOOLS				
BONE FRACTURE OR JOIN INJURY				
CANCER				
CATARACTS				
CHEST PAIN				
CHICKEN POX				
CHRONIC COUGH				
CHRONIC FATIGUE				
COLD NUMB FEET				
COLITIS				
CONSTIPATION				
CROHN'S DISEASE				
DECREASE IN FLOW OR FORCE OF URINE				
DECREASED HEARING				
DEPRESSION/MOODINESS				
DIABETES				

Patient Medical History Form *continued…*

Patient Name: _____ **Date of Birth**: _____/_____/_____

CONDITION	PAST	CURRENT	DATE/ AGE ONSET:	DATE/AGE RESOLVED:
DIARRHEA				
DIFFICULTY SWALLOWING				
DIVERTICULOSIS				
DIZZY SPELLS				
DOUBLE OR BLURRED VISION				
DRUG ABUSE/ADDICTION				
EAR INFECTIONS- FREQUENT				
ECZEMA				
EPILEPSY				
EYE PAIN				
FAILING VISION				
FAINTING SPELLS				
FEELINGS OF WORTHLESSNESS				
FOOT PAIN				
GALL BLADDER TROUBLE				
GERMAN MEASLES				
GLAUCOMA				
GOUT				
HEADACHES/MIGRAINE				
HEART DISEASE				
HEART MURMUR				
HEARTBURN				
HEMORRHOIDS				
HERNIA				
HERPES				
HIGH BLOOD PRESSURE				
HIGH CHOLESTEROL				
HOARSENESS- PROLONGED				
IRREGULAR PULSE/HEART PALPITATIONS				
JAUNDICE/ HEPATITIS				
KIDNEY STONES				
LEG PAIN- WHEN WALKING				
LOSS OF APPETITE – RECENT				
LOSS OF CONTROL OF BLADDER-URINATION				
MEASLES				
MEMORY LOSS				
MENTAL ILLNESS				
MUMPS				
NERVOUSNESS				
NOSE BLEED- FREQUENT OR RECURRENT				
NUMBNESS-TINGLING SENSATIONS				
OSTEOPOROSIS				
OTHER:				
PAINFUL URINATION				
PEPTIC ULCER				
PERSISTENT NAUSEA/ VOMITING				

Patient Medical History Form *continued…*

Patient Name: _____ **Date of Birth**: _____/_____/_____

CONDITION	PAST	CURRENT	DATE/ AGE ONSET:	DATE/AGE RESOLVED:
PHOBIAS				
PNEUMONIA/ PLEURISY				
POLIO				
PSORIASIS				
RASHES/HIVES				
RECENT HAIR LOSS				
RECENT UNEXPECTED WEIGHT CHANGE				
RHEUMATIC FEVER				
RINGING IN EAR				
SCARLET FEVER				
SEVERE DEPRESSION				
SHORTNESS OF BREATH WHILE ACTIVE				
SHORTNESS OF BREATH WHILE AT REST				
SINUS TROUBLE				
SLEEPING DIFFICULTY				
SORE THROAT- FREQUENT				
STROKE				
SUICIDAL IDEATIONS				
SWOLLEN ANKLES				
THYROID DISEASE				
TREMOR				
TROUBLE WITH CONCENTRATION				
TUBERCULOSIS				
URETHRAL DISCHARGE				
URINATION MORE THAN TWICE AT NIGHT				
URINE/BLADDER INFECTIONS – FREQUENT				
VARICOSE VEINS/PHLEBITIS				
VENEREAL DISEASE				
WHEEZING				
OTHER:				

Procedures and Surgeries: □ NONE (If yes, please list all Procedures/Surgeries and indicate when. Ex.: Tonsillectomy-2005

Procedure/ Surgery:	When:

	DATE	PLACE/NAME OF DOCTOR
Last Colonoscopy		
Last Mammogram		
Last Pap Smear		
Last Eye Exam		
Last Bone Density Scan		

***Patient Medical History Form** continued…*

Family History: Does any of the below condition apply to your relative(s)? If so, please mark (x) accordingly.

TYPE	MOTHER	FATHER	SISTER	BROTHER	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcohol Abuse								
Allergies								
Anemia								
Arthritis								
Asthma								
Bleeding Easily								
Cancer: 1.								
2.								
3.								
4.								
Diabetes								
Epilepsy								
Glaucoma								
Headache/ Migraine								
Heart Disease								
High Blood Pressure								
High Cholesterol								
Mental Illness								
Osteoporosis								
Severe Depression								
Stroke								
Thyroid Disease								
Other:								

Social History:

ALCOHOL USE:	TYPE (PLEASE CIRCLE)	AMOUNT AND FREQUENCY
□ CURRENT □ PAST □ NEVER □ QUIT SINCE: _____	Beer, Wine, Liquor Other: _____	
TOBACCO USE:	TYPE (PLEASE CIRCLE)	AMOUNT AND FREQUENCY
□ CURRENT □ PAST □ NEVER □ QUIT SINCE: _____	Cigarettes, Cigars, Snuffs, E-Cigarette Other: _____	
SUBSTANCE/DRUG USE:	TYPE (PLEASE CIRCLE)	AMOUNT AND FREQUENCY
□ CURRENT □ PAST □ NEVER □ QUIT SINCE: _____	Marijuana, Cocaine, Heroin, Opioids Other: _____	

Patient Medical History Form *continued…*

Pregnancies:

Please complete below for all pregnancies including abortions, miscarriages, etc.

DATE/ TIME	NUMBER OF WKS. PREGNANT	PREGNANCY/ DELIVERY OUTCOME	LENGTH OF LABOR	SEX OF THE BABY	WEIGHT	ANESTHESIA	HOSPITAL
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

DO YOU HAVE A LIVING WILL or ADVANCED DIRECTIVE? This is to indicate your wishes in the event of clinical changes to your health.	□ YES □ NO

Other Specialist(s) Seen Currently

TYPE OF SPECIALTY	REASON TO SEE SPECIALIST	PHYSICIAN/PRACTICE NAME	PHONE #

I certify that the information contained herein is complete and accurate to the best of my knowledge.

_____

Patient Signature Date

Patient Medical History Form *continued…*

Patient Name: _____ **Date of Birth**: _____/_____/_____

Employment and Education

Status:	**Work Hazards:**	**Activity Level:**
□ Employed □ Retired □ Disability □ Student □ Part-Time □ Unemployed Other: _____ **Do you operate any hazardous equipment?** Y / N	□ Hazardous Materials □ Repetitive Motion □ Heavy Lifting/Twisting □ Shift/Night Work □ Loud Noises □ Vibration □ Medical/Clinical Work Other: _____	□ Desk/Office □ Moderate Physical Work □ Occasional Physical Work □ Heavy Physical Work Other: _____

Previous Employment/School:	**Highest Education:**	**School Concerns:**
_____ _____ _____ _____ Additional Information: _____ _____	□ None □ Bachelor's Degree □ Elementary School □ Master's Degree □ High School/GED □ Adv. Graduate or Ph.D. □ Middle School □ Some College	□ Learning □ Health □ Social □ Cultural □ Communication □ Other: Additional Information: _____ _____

Home and Environment

Marital Status:	**Lives With:**	**Living Situation:**
□ Single □ Separate □ Married □ Never Married □ Married (Living Together) □ Divorce □ Life Partner □ Widowed □ Annulled Other:_____	□ Self □ Mother □ Children □ Roomate(s)/ Friend(s) □ Family □ Siblings □ Father □ Significant Other □ Foster Family □ Spouse □ Grandparents Other: _____	□ Home/Independent □ Home with Assistance Physical Work □ Homeless/Shelter Other: _____ **Number of Children:** _____

Environment Screening

Have you experience any abuse in your house hold?	**Do you feel unsafe at home?** Y / N **Do you have a safe place to go?** Y / N **Do you have Family/Friends available to help?** Y / N	**Have you notified any Agencies about your abuse?** Y / N **Agency(s)/Others Notified:** _____ _____
_____ _____ _____ _____ _____		

Patient Medical History Form *continued…*

Patient Name: _____ **Date of Birth**: _____/_____/_____

Nutrition and Health

Briefly write your routine diet:	Type of Diet:	OTHER:
	□ Regular □ Calorie Restricted □ Diabetic □ Dysphagia Diet □ Ketogenic Diet □ Kosher □ Low Carbohydrate □ Low Fat □ Low Sodium □ Renal □ Total Parenteral Nutrition □ Vegetarian Other: _____	Diet Restrictions: _____ _____ Caffeine intake amount: _____ **Do you want to lose weight?** Y / N

Vitamins/Alternative Health	Eating Disorders:	OTHER:
Vitamins/Supplements: _____ _____ Uses Alternative Healthcare: _____ _____	□ Bulimia □ Anorexia Nervosa □ Overeating Other: _____ _____ _____	**Sleeping concerns?** Y / N _____ _____ **Feeling highly Stressed?** Y / N _____ _____

Exercise and Physical Activity

Exercises	Exercise Type:	Self Assessment
How many times per week? □ Never □ 1-2 times □ 3-4 times □ 5-6 times □ Daily Other: _____	**Duration (Average # of minutes):** _____ □ Aerobics □ Bicycling □ Organized Team Sports □ PE Class □ Running □ Swimming □ Walking □ Weight Lifting □ Yoga Other: _____	□ Poor Condition □ Fair Condition □ Good Condition □ Excellent Condition Other/Comment: _____ _____ _____

Patient Name: _____ **Date of Birth**: _____/_____/_____

Sexual Activity

Activity	Orientation:	Contraceptive Use Details
Are you Sexually Active? Y / N **When were you first active?** **Age:_____** **Number of lifetime partners**: _____ **Number of current partners**: _____	**Self describe orientation:** □ Heterosexual □ Bisexual □ Homosexual □ Transgender Other: _____ **Do you use condoms?** Y / N	□ Abstinence □ Condoms □ Birth Control Implant □ Intrauterine Device □ Birth Control PATCH □ Vaginal Ring □ Birth Control PILL □ None □ Birth Control SHOT Other Contraceptive Use/Comment: _____

History of Abuse	Other Related Concerns:
Have you ever been sexually abused? Y / N Comment: _____ _____ _____	

Our Financial Policy

Thank you for choosing us as your medical provider. We are committed to provide you with a consistently high standard of care and pleased to discuss our services at any time. Your clear understanding of our Financial Policy is an important part of our professional relationship. We request that you take time to **review, understand, and sign below** prior to receiving treatment from us.

It is your responsibility to advise us of any change in your address, telephone number, insurance and HIPAA information.

You are expected to present your current insurance card(s) at each visit. Any minor patient must be accompanied by an adult representative who has assumed financial responsibility for the minor patient. To protect patients from identity theft, we also ask that you present a photo identification card at time of visit.

Your insurance is a contract between you and your insurance company. We are not a party to the contract. It is very important that you understand the provisions of your policy. We will file an insurance claim as a courtesy to our patients however this does not release you of your financial responsibility.

If your insurance pays only a portion of the bill or rejects your claim, you will be responsible for the timely payment of your account. For those who request it, we provide an estimate of the cost of the service to be performed, if such information is available to us.

If you have more than one insurance plan, it is your responsibility to inform us regarding the order of how we should file your claim and coordinate with your insurances as well.

If you do not have insurance, or we do not participate with your insurance company, you will be expected to pay in full at the time of visit.

We will collect your co-payment, deductible, balances, or charge for non-covered services at the time of your visit.

We accept cash, checks, or major credit cards.

We follow the fee schedules set forth by the Board of Professional Regulation for charging for reproduction of medical records. We charge a $15 fee for completion of forms. (ie: FMLA forms)

When you schedule an appointment, time is specifically allocated for you. We ask that you notify us at least 24 hours in advance if you are unable to keep your appointment to avoid a "No Show" fee:

- $30 for established patient
- $60 for new patient
- $60 for physicals & pap smear

We reserve the right to take lawful actions including referring your account to a collections agency and report to one or more credit bureaus for non-payment.

If account is transferred to the collection agency, an additional 33% will be added to your balance to cover the agency fees!

Thank you for taking time to review our financial policy. If you have any questions, please ask to speak with our Practice Manager.

Patient/Authorized Representative Name: _____

Signature: _____ **Date**: _____ _____

Middletown Familycare Associates

HIPAA Notice of Privacy Practices

Effective Date: April 28, 2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

OUR OBLIGATIONS

We are required by law to:

- *Maintain the privacy of protected health information*
- *Give you this notice of our legal duties and privacy practices regarding health information about you*
- *Follow the terms of our notice that is currently in effect*

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. *Uses and disclosures of Protected Health Information for marketing purposes; and*
2. *Disclosures that constitute a sale of your Protected Health Information*

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Middletown Family Care Assoc., LLC

YOUR RIGHTS

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the Practice Administrator. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the Medical Director.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Practice Administrator.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the Practice Administrator. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Practice Administrator. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, *www.middletownfamilycare.com*. To obtain a paper copy of this notice, please write to: Practice Administrator.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. If you wish to file a complaint with our office, contact our Privacy and Security Officer. All complaints must be made in writing. ***You will not be penalized for filing a complaint.***

QUESTIONS

If you have any questions about this notice, please contact our Privacy and Security Officer at:

Middletown Familycare Associates, L.L.C
Attn: Guni Dedhia
Address: 114 Sandhill Dr. Suite 101 Middletown, De 19709
Phone: 302-378-4779

Thank you for taking time to review our Notice of Privacy Practices.

Notice of Privacy Practices

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Middletown Family Care Associates, LLC. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully.

I, _____ acknowledge receipt of the Notice of Privacy Practices.
(Print name)

_____ _____
(Patient or Guardian Signature) *Date*

IQHealth

Welcome to Your Secure Patient Portal!

Dear Patient,

We are excited to offer you a new informational system through United Medical Physicians called **IQHealth**. This system allows web based interactions between patients and our office. You will be able to:

View your test results
Request an appointment
Request medication refills
Update demographic information
Send and receive messages
Keep track of your health

In order to take advantage of this new feature, we will need your email address. You will then receive a one-time secure email invitation from **IQHealth.com** to set up an account. Simply click on the link in your email and follow the prompts to activate your account. For any questions or concerns please contact the office for assistance.

We hope this new system will make communication with our office easier and more convenient. If you choose not to participate, you may still contact the office via telephone and mail.

Sincerely,

Middletown Family Care Associates, LLC

I wish to participate
Name: _____
Date of Birth: _____
Email Address: _____
Last 4 digits of SSN: _____

I do not wish to participate
Name: _____

Attendance Policy

Middletown FamilyCare is committed to providing quality care to all our patients. It is important for patients to keep their appointment times. NO SHOW appointments result in unused Physician/Medical Assistant times in which another patient could be treated.

It is the obligation of each patient to call and notify Middletown FamilyCare Associates when an appointment cannot be kept.

- Notification of a cancellation must occur at least 24 hours prior to your appointment, unless it is an emergency, or it will be documented as a NO SHOW. (A cancellation without notification)
- Two consecutive NO SHOWS or three accumulated NO SHOWS may result in patient being discharged form our practice.
- Excessive cancellations with or without notification may also result in patient discharge from our practice.

Policy Notification

Each patient will be notified of the Middletown FamilyCare Associates attendance policy. Cancellations or request for change of appointment times are made by calling our office phone, depending on the location of your appointment. See Phone numbers above.

Patient (Guardian) Signature _____ Date _____

Authorization To Fax Medical Records

I authorize the staff of Middletown Family Care Associates to fax any and all information pertinent to my healthcare to any emergency center or to any medical institution or to another doctor who might be called upon to participate in my medical care.

I realized that there is a small possibility that, mistakenly, the fax information could be sent to an incorrect number.

Patient (Guardian) Signature: _____ Date: _____

Witness: _____ Date: _____

MIDDLETOWN FAMILY CARE ASSOCIATES, L.L.C.

IMPORTANT NOTICE REGARDING YOUR WELLNESS/PHYSICAL EXAM VISIT

- Please be aware that most insurances cover 100% of the cost of Physical Exams if you have not had one in the past year or two. If you are unsure how often it is covered by your insurance plan, please contact your insurance company directly.
- If you have a specific medical problem or concerns that you would like to discuss with your provider during your Physical Exam appointment, please be aware of the following:
    - Depending on the specific problem or urgency of the matter, we may not be able to address both the physical and your problem on the same day
    - **If we proceed with addressing your specific problem in addition to the Physical Exam, your insurance company may require you to pay a COPAY and/or DEDUCTIBLE**
    - Due to insurance guidelines, we are required to document everything medically-related to your visit; therefore, if your insurance company deems that your problem is not part of the routine physical exam, your insurance company may require you to pay a copay and/or deductible

- If medical problems are discovered during your exam and require attention, your provider may address the problem with the understanding that you may be responsible to pay a copay and/or deductible as outlined above

Physical Exams include the following services from your healthcare provider:

- review your medical history, medications, health screenings for which you are due based on your demographic information – if you are due for any, they will provide orders
- Physical exam which includes but is not limited to the following: vital signs (temperature, blood pressure, pulse, oximetry, height, weight), check vision, listen to lungs, heart, abdomen/stomach and other body system checks as needed
- Order bloodwork as needed including but not limited to blood counts, comprehensive metabolic panel (liver, kidneys, electrolytes, hemoglobin A1c, etc.)
- Order age and risk-appropriate cancer screenings (colonoscopy, mammogram, pap smear, etc.)

Patient Acknowledgement

By signing this document, I certify that I have read and understand its content. Further, I understand that depending on my insurance benefit, I may be responsible for a copay and/or deductible for services provided outside of my routine physical exam as indicated above.

Patient name:_____ DOB:_____

Patient/Guardian Signature: _____ Date: _____

Request for Records Release

114 Sandhill Dr., Suite 101
Middletown, DE 19709
Tel. # (302) 378 – 4779
Fax: (302) 378 – 4789

Laxmichand Dedhia, MD
Neilay Dedhia, DO
Mini Mathew, FNP
Jignesh Patel, PA
Cara O'Reilly, FNP

PATIENT NAME _____ DATE OF BIRTH _____

ADDRESS _____ LAST 4-DIGITS OF SSN _____

PHONE # _____

FROM:	**TO:**
Physician/Facility: _____	Physician/Facility: _____
Address: _____	Address: _____
_____	_____
Phone # _____	Phone # _____
Fax # _____	Fax # _____

INFORMATION TO BE RELEASED

□ Complete Medical Records
□ Recent H & P
□ Lab Reports
□ Radiology Reports
□ Hospital Reports
□ Last 3 Visits

□ Other:

REASON FOR THIS REQUEST

□ Transfer of Care (*Please provide a brief reason below*)
□ Change in Health Insurance
□ Patient Request (Personal Use)

□ Other:

METHOD OF DISCLOSURE

□ Pick Up (Name of Individual who will pick up your records):

_____

□ Fax #: _____

□ Mail to: _____

_____

Description of information you **DO NOT** authorize to be disclosed if any: (Subject to Provider's approval)

***** PLEASE ALLOW 14 BUSINESS DAYS FOR ALL MEDICAL RECORDS REQUESTS. *****

Request for Records Release

114 Sandhill Dr., Suite 101
Middletown, DE 19709
Tel. # (302) 378 – 4779
Fax: (302) 378 – 4789

Laxmichand Dedhia, MD
Neilay Dedhia, DO
Mini Mathew, FNP
Jignesh Patel, PA
Cara O'Reilly, FNP

By signing below, I certify that:

- I understand that I may inspect a copy of the records being disclosed
- I understand that unless excluded and noted herein the information being disclosed may contain sensitive information such as sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, physical abuse, or treatment for drug and alcohol abuse and psychotherapy notes.
- I understand that this authorization will expire in 3 months following the date of this authorization.
- I understand that I may revoke this authorization at any time (except to the extent that the information was already disclosed on reliance on this signed authorization) by notifying the provider's office in writing.
- I understand that if the person or organization that receives information is not covered by privacy regulations, the information may be disclosed and would no longer be protected.
- I understand that there may be a fee for copying/ supplying medical records. Middletown Family Care Associates, LLC follows the state regulations in regards to the fee schedule for copying charts.
    - $2.00 per page for pages 1 – 10
    - $1.00 per page for pages 11 – 20
    - $.90 per page for pages 21 – 60
    - $0.50 per page for pages 61 and above
- I understand that I have the right to receive a copy of this form.
- I understand that photo ID is required if the medical records are being picked up by another individual

I authorize the release of all information indicated. I release Middletown Family Care Associates, LLC from all legal responsibility and/or liability that may arise from the release of the records I have specified.

PATIENT NAME _____ DATE _____

DOB _____ ADDRESS _____

PHONE # _____

X _____ _____

PATIENT/PARENT/GUARDIAN/CAREGIVER SIGNATURE RELATIONSHIP TO PATIENT