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!

MIDDLETOWN FAMILY CARE ASSOCIATES, LLC

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 ☐ Loud Noises ☐ Shift/Night Work ☐ Medical/Clinical Work ☐ Vibration 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: _____ _____ _____

nt Medical History Form *continued…*

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,LLC

middletownfamilycare.com

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

Notice of Privacy Practices

Adapted from HHS. Version effective as of 2/13/26:

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

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care

- Market our services
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

Middletown FamilyCare Associates, LLC does NOT sell your information to third parties.

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.
- You have access to your health information through our portal - IQHealth

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, office, or cell 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," for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.
- 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). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

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 someone has authority to act as your personal representative, such as if someone has your 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 **https://www.hhs.gov/hipaa/filing-a-complaint/index.html.**
- 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 or payment for 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.

If we have your substance use disorder patient records, subject to 42 CFR part 2, we will give you clear and obvious notice in advance and a choice about whether to receive fundraising communications that use your Part 2 information.

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.

Middletown FamilyCare Associates, LLC is a part of the United Medical Accountable Care Organization. As such, your health information is shared with this entity for treatment, payment, and operations related to the practice and accountable care organization.

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.

In all cases, including those listed below, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

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're 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 in this notice 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.

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

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

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