United Medical Accountable Care Organization
161 Becks Woods Drive
Bear, DE 19701
Tel. 302-451-5600
Fax 302-451-5614

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 no show fee.
2) **FOR 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 complete the following items and send it to us electronically via IQ Health 3 days before your scheduled appointment**:
      - ***Patient Registration*** *Form, completely filled-out and signed*
      - ***Financial Policy Form,*** *completely reviewed and signed*
      - ***Medical History Form****, completely filled-out and signed*
      - ***Consent Form****, completely filled-out and signed*
      - ***Medical History*** *completely filled-out from IQ Health portal ECLIP BOARD*
3) ***To bring at the time of your visit:***
      - *Valid* ***insurance card****(s)*
      - ***Photo ID****, preferably state issued/ student ID for minor*
      - ***Co-pay****, if it applies to your insurance*

******PLEASE BE AWARE THAT FAILURE TO COMPLETE AND BRING THE ABOVE ITEMS WITH YOU MAY RESULT TO RESCHEDULING YOUR APPOINTMENT* *****

4) ***Registration through our IQ Health Patient Portal***
   - Access to our online patient portal is a must in order to efficiently communicate with our office.
   - Your email address will be required for the set up.
   - This portal allows you to be able to do the following:
     - ❖ View Your Visit Summary/Test Results
     - ❖ Request an appointment
     - ❖ Request medication refills
     - ❖ Update demographic information
     - ❖ Send and receive non-urgent messages
     - ❖ Keep track of your health

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!

IMPORTANT INFORMATION ABOUT OUR PRACTICE

Dear Patient,

We want to inform you that our practice proudly participates within the ***United Medical Accountable Care Organization (UMACO)*** network of providers.

What is an ACO? An ACO is a group of doctors, hospitals, and/or other health care providers working together to give you better, more coordinated service and health care. We share important information and resources about your individual needs and preferences.

What are the benefits to me as a patient?

- **Accessibility** – ACO and Medical Homes are focused on increasing accessibility to treatment for patients.
  - Same day appointments for sick visits
  - Extended office hours during the week and sometimes Saturday hours
  - Medical records can easily be accessed by providers involved with the patient's care.
- **Care Coordination and Communication** - provide a care team which coordinates efforts to provide better patient care. Communication lines are open among providers as well as between primary care and patients.
- **Better Quality Care at a Lower Cost -** ACOs are focused upon providing quality outcomes while simultaneously reducing costs. Under ACOs, only necessary tests are run. Reimbursement is based upon quality as opposed to quantity. Additionally, with the emphasis on care coordination, providers can easily check to see what tests/services have previously been performed. This avoids duplication and makes strides toward reducing costs for both unnecessary and duplicate tests/services.
- **Reduced Paperwork** – An ACO also benefits patients by reducing the amount of paperwork required to be completed. All of the medical records are right there and readily accessible. The emphasis becomes more on verifying pertinent information such as insurance and census data rather than spending hours filling out paperwork and filling out the same paperwork for different providers.
- **Primary Care Physician** – Under a Medical Home and ACO model, the primary care physician serves as the primary contact for all medical questions, issues, or requests for medical information. The primary care physician is responsible for coordinating care and obtaining all relevant medical information from other providers including specialists, laboratories, and diagnostic imaging. It becomes as easy as one-stop shopping.
- **Two-Way Communication** – ACOs provide a means of two-way communication with their primary care physician. Patients become involved in the decisions surrounding their healthcare. No longer does the physician just determine treatment without patient input, but it becomes a give and take conversation. Discussions around the different options available take place with the pros and cons of each, whereby the patient and the provider jointly make the decisions as to the best course of treatment.

What should the patient expect as being part of the ACO?

- **Care Coordination Communication –** Receiving a call and or letter from our care coordination department, which is an extension of our office for follow up appointments, consultation visits with specialist, preventive screenings and others pertaining to your care.
- **After Hours Urgent Calls –** Calling the office after hours for anything urgent or prior to going to the hospital.
- **In-Network Referrals –** Preferred in-network providers to be utilized for better coordination of care.
- **Cost Education –** Access to appropriate, reliable information for the cost of care.

PATIENT DEMOGRAPHIC INFORMATION

Today's Date:	Last Name:	First Name:	MI:	Gender:

Street Address:	City:	State:	Zip Code:

Marital Status:	Social Security #:	Date of Birth:	Age:	Occupation:

Home Phone:	Cell Phone:	Work Phone:	Email Address:

Responsible Party:	Date of Birth:	Social Security #:
		- -

Home #	Work #	Cell #	Relationship to Patient:

Address:		**Employer:**
City/State/Zip:		

Emergency Contact:	Relationship to Patient:

Phone: Home #	Work #	Cell #

Insurance Carrier	Primary Holder Name	Date of Birth:

Effective Date	ID #	Group #

AUTHORIZATION AND ACKNOWLEDGEMENT

Please initial and sign at the bottom:

________ **Authorization and Assignment of Benefits:** I hereby give permission to UMACO 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 UMACO. 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.

________ **HIPAA Privacy Acknowledgement:** I hereby acknowledge that I have received and reviewed the NOTICE OF THE PRIVACY PRACTICES from UMACO.

_______ I ACKNOWLEDGE THAT MY PRIMARY CARE/SPECIALTY PROVIDER IS PART OF THE UMACO NETWORK OF INDEPENDENTLY OWNED PRIMARY CARE AND SPECIALTY PRACTICES RECOGNIZED AS ONE ENTITY PROVIDING QUALITY CARE TO PATIENTS.

Patient or Guardian Signature: ___________________________________ **Relationship:** _________________ **Date:** ________________

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.

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.

It is your responsibility to advise us of any change in your address, telephone number, or employer information.

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 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.

We will collect your co-payment, deductible, balances, or charge for non-covered services at the time of your visit. We will not be responsible for any disputes between you and your insurance company regarding copays, deductible, covered charges, etc. other than to supply factual information.

Patients with High Deductible Plans will be asked to pay a pre-payment deposit of $75 prior to service. If deductible has been satisfied with verification from the carrier, only the co-payment is required, if applicable.

We cannot guarantee payment of all claims. 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 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 accept cash, checks, or major credit cards. It is our policy to charge a $35 fee for returned check.

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 $25 “No Show” fee for established patient and $50 “No Show” fee for new patient. If three appointments are missed, you will be dismissed from the practice for non-compliance.

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.

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: ____________________________________ ________

Patient Consent for Use and Disclosure of Protected Health Information

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

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

With my consent, UMACO may disclose my PHI to the following individuals (family, relatives, or friends) who may assist in my care:

Name	Relationship	Home #:	Work #:	Cell #:

Please indicate name, contact numbers, and relationship of individuals to whom UMACO may release PHI.

I have the right to review the Notice of Privacy Practices prior to signing this consent. UMACO 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, UMACO 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 UMACO 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, UMACO may mail to my home or other designated location any item that may assist UMACO 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, UMACO may e-mail to my designated e-mail address any message in reference to any item that may assist in my care.

UMACO 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 UMACO restricts how it uses or discloses my PHI to carry out the TPO, However,
UMACO 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 UMACO's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that UMACO has already made disclosure in reliance upon my prior consent. If I do not sign this consent, UMACO 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)