Middletown Family Care Assoc., LLC

Experience the caring atmosphere
for your family & friends.

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 - Friday: 8am-6:30pm
Saturday: 9am-1pm

Our on-call doctors 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!

Patient Centered Medical Home

What is a Medical Home?

A **Medical Home** is not a place or somewhere you would go, it simply means an applied **team-based approach** by your primary healthcare provider, where integrated care can help maximize your overall healthcare outcome!

The Patient Centered Medical Home (PCMH) model practice emphasizes in care coordination and improved communication in order to provide **quality care**, **lower medical costs**, and provide an **excellent patient care experience**.

How does this affect you?

As part of our commitment to provide you with the highest standard of care, by practicing a team-based approach for better care and communication as well as using innovative and secured tools for improved health care access. We partner with you and collaborate with your other providers to achieve the best quality tailored care we can offer!

Did you know?

You can prolong your life and lower the cost of your healthcare, just by taking control of your health. Having an annual exam with your provider can help assess and improve your overall health and well-being.

Our role as your trusted HEALTHCARE TEAM

- Provide a safe and healthy healthcare environment.
- Partner with you in making your healthcare decisions.
- Coordinate with you, your authorized representatives, and other healthcare providers.
- Keep you informed and on-track by providing:
  - *Health Coaching*
  - *Self-Care Management Support*
  - *Health resources*
  - *Preventive care*
  - *Tailored care*

Your role as a PATIENT

- Communicate closely with us.
- Keep us up-to-date with your medications, immunizations, allergies, conditions, tests, consultations, and hospitalizations.
- Advise of any changes about you and your families' medical history.
- Inform and authorize your other providers to coordinate with us.
- Participate in decisions about your health.
- Follow treatment plans and self-care management directions.
- Speak up and ask questions!

To learn more about PCMH, please ask for Anna Siegel.

Meet Our Care Teams

At Middletown Family Care Assoc., we formed our care teams in order to provide tailored care for each of our patient needs. Every patient is assigned to a care team.

What is a Care Team?

A care team is group of health professionals and support staff working together with the patient to achieve a common purpose. As a patient, YOU are the team captain of your team!

Why Patient Care Teams?

Patient-centered care teams deliver care that is respectful of and responsive to their individual patient preferences, needs, and values.

CARE TEAM ROLES

Primary Care Provider (PCP)

Your PCP is the physician who knows you best and who is ultimately responsible for your overall medical care. He or She prescribes medications and orders any necessary screening and diagnostic studies, referrals to specialists, and any other medical treatment. Your PCP also discusses and reviews your care plan and goals with you.

Physician Assistant (PA)

Your PA is a specially trained professional who works collaboratively with your physician. He or she can diagnose and treat many of the same conditions as your PCP and can order tests and prescribe medications. They also work very closely with your PCP in reviewing your care plan and goals with you.

Medical Assistant (MA)

Your MA is the person that escorts you from the waiting room to the exam room, takes your vital signs and updates your clinical information in your medical record. They can also perform certain diagnostic tests like EKG, draw your blood, and administer injections.

Patient Service Coordinator (PSC)

Your PSC is the person who obtains your current demographic and insurance information. He or she also schedules your appointments, works with your insurance, and helps coordinate your care across settings by following up with you after you are seen by another provider or reminds you regarding studies that you need done.

OUR CARE TEAMS

TEAM A			TEAM B		
Lax Dedhia, MD	Haley Sparks, PA-C	Mini Mathew, NP-C	Jill Mackey, MD	Michele Tjaden, NP-C	Megan Kerstetter, F-NP
Anna S.	Nicci R.	Sarah F.	Adriana C.	Katie J.	Ashley T.
Megan L.	Rebecca M.	Ashley T.	Jessica D.	Melissa M.	

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 □ 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: _____ _____ _____

ıt 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**: _____

What is a Patient Centered Medical Home?

MIDDLETOWN FAMILY CARE ASSOC. is dedicated to providing our patients with the highest standard of care. We believe that our patients receive the best possible care when they participate in their medical treatment. A **Patient Centered Medical Home** is a partnership between an informed patient and authorized representatives and a physician-led care team.

As your medical home, we will:

- ✓ Allow you to select a personal clinician and care team who will know you
- ✓ Help improve your overall well-being including behavioral health by learning about you, your family, life situation, and health preferences
- ✓ Respect your privacy and keep your information confidential unless you give us written permission or it is required by law
- ✓ Inform you about your health condition in a way you can understand
- ✓ Take care of your short term illness, long term chronic disease, and preventive care
- ✓ Collaborate with your other health care providers to coordinate your care
- ✓ Notify you of your test results using our patient portal or by phone
- ✓ Keep you up to date on all your vaccines and preventive studies
- ✓ Remind you when tests are due to help prevent delays in your diagnosis and treatment
- ✓ Use current evidence-based guidelines and provide self-care management support
- ✓ Give the care that meets your needs and fits your goals and values
- ✓ Discuss and review your care plan and provide educational resources
- ✓ Give you information about classes, support groups, or other services that can help you learn more about your condition and stay healthy

Other important information:

- ✓ We have extended hours: Monday to Friday 8:00am-6:30pm and Saturday 9:00am-1:00pm.
- ✓ Our on-call physicians are available to speak with after-hours by calling our main office numbers
- ✓ We encourage you to use IQ Health, our secured patient portal to access your health information and communicate with us for non-urgent matters during and after office hours.

We trust you, our patient to:

- ✓ Participate as a full partner in your care
- ✓ Understand your health condition and let us know if there is something you do not understand
- ✓ Inform us about your health needs and concerns
- ✓ Take your medications as prescribed
- ✓ Come to each visit with any updates on medications, dietary supplements, or remedies you are using and let us know if you need a refill
- ✓ Keep us up-to-date with changes in your personal, family, medical and social history
- ✓ Inform us if you were seen by any other provider or at any facility and/or if you had any test ordered and/or medications prescribed by them
- ✓ Ask other providers to send us your reports
- ✓ Know what your insurance covers and let us know if a service is not covered; pay your share of any fees
- ✓ Keep your scheduled appointments and notify us at least 24 hours prior if you need to cancel
- ✓ Call us if you do not receive your test results within 2 weeks
- ✓ If possible, inform us if you are going to the Emergency room so that we can assist with your treatment
- ✓ Follow the care plan that you have agreed upon, or let us know why you cannot so we can try to help and change the plan
- ✓ Give us feedback on how we can improve our services

Either you or your doctor may end this partnership at any time. If you choose to end this partnership, please notify us and tell us why. Thank you for choosing us as your health partner! Please acknowledge below.

Patient Name: _____ DOB: _____

_____

Patient Signature Date

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: _____