DELAWARE FAMILY MEDICINE

Providing Excellent Medical Care for Your Family

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www.delawarefamilymedicine.com

Name: _____ Date of Birth:____/_____/_____

Address: _____ City/ State: _____ Zip: _____

SSN: _____-_____-_____ Race: _____ Ethnicity: _____

Phone #: _____ Cell: _____

Would you like to receive text message appointment reminders: _____

Birth Sex: ☐ Male ☐ Female Gender Identity: _____

Email Address: _____

Name of Emergency Contact: _____

Relationship to you: _____Emergency Contacts Number: _____

Allergies: List and ADD severity and Reaction ☐ **No Known Allergies**

Name of allergy

_____

Severity/Reaction

_____

Medications: ☐ **I do not take any medications**

List all current Over the Counter and Prescribed Medications with their corresponding dosages (If known)

_____

_____

_____

****Please list one Local Pharmacy for all your medications, any change of pharmacy may delay the refill of the medications**

Name of Local Pharmacy: _____ Phone Number: _____

Name of Mail in Pharmacy: _____ Phone Number: _____

Personal Medical History:

☐ No Known Problems ☐ Yes. If so, please list all current & past medical problems.

_____

_____

_____

Date of Last Eye Exam: _____ Place it was done: _____

Date of Last blood work: _____ Place it was done: _____

Date of Last Colonoscopy: _____ Place it was done: _____

Date of Last Pap smear: _____ Place it was done: _____

Date of Last Mammogram: _____ Place it was done: _____

Any other Screenings: _____ Place it was done:_____

_____

Procedures & Surgeries:

☐ None ☐ Yes (**If so, please add dates.** Ex: Tonsillectomy,2005)

_____

_____

_____

Family History

☐ Negative ☐ Unknown ☐ Adopted

Type	Mother	Father	Sister	Brother	Grandmother Maternal	Grandmother Paternal	Grandfather Maternal	Grandfather Paternal
Alzheimer's								
Arthritis								
Cancer								
Diabetes								
Heart Disease								
High Cholesterol								
Hypertension								
Kidney Disease								
Mental Illness								
Osteoporosis								
Seizures								
Thyroid Disease								
OTHER:								

Alcohol Use: ☐ Never ☐ Past ☐ Current *Please circle if applicable: Beer | Wine | Liquor

Tobacco Use: ☐ Never ☐ Past ☐ Current

* Please circle if applicable: Cigarettes| E-Cigarettes| Cigars |Vape | Oral | Pipe | Snuff

Cigarettes: How many a day? _____

E-Cigarettes or Vape: How often a day? _____

Substance Abuse: ☐ Never ☐ Past ☐ Current. Please specify the type: _____

**This includes Marijuana Medical and recreational, Please Specify.*

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment: ☐ Employed ☐ Disability ☐ Retired ☐ Student ☐ Unemployed **Exercise/Physical Activity**: Times per week: ____ Duration**:** _____ specify: _____

IQ Health- Welcome to Your Secure Patient Portal

We are excited to offer you a new informational system through United Medical Physicians called IQ Health. 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

☐ I wish to participate ☐ I do NOT wish to participate

***If participating in IQ Health please make sure to provide your email on Page 1

SATURDAY NO-SHOW FEE POLICY

(_____) Please initial. We make every effort to provide prompt medical care to all of our patients. Should you need to cancel your appointment this must be done 48 hours prior to your appointment, this allows other patients who may be waiting to see the doctor to use the available appointment time. A **NO SHOW** is when a patient fails to keep a scheduled appointment. A **NO SHOW** will generate a **$50** fee and three no shows may require that you seek your medical care elsewhere. **If you receive one Saturday No Show you are no longer able to be scheduled on Saturdays.**

Patient Privacy Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as the quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how private information is used or disclosed to carry our treatment, payment or healthcare operations. I also Understand you are not required to agree to my requested restrictions, but if you do agree then you are abounded to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Assignment of Benefits: I hereby assign all medical and surgical benefits to which I am entitled to including Medicare,Medicaid,Private Insurance and any other health plans to Galicano F. Inguito JR.,MD. I authorize than any holder of medical information about me, to release to my insurance company and to my supplemental insurer and information needed to determine these benefits payable for medical and related services provided by Galicano F. Inguito JR.,MD.

Signature:_____ Date:_____

OFFICE POLICY

Please take the time to read our office policy and initial beside each one. This form applies to all patients of Delaware Family Medicine. If you have any questions please feel free to ask one of our staff.

(_____) Patients with Insurance. Although we bill the patient's insurance company for services rendered, the patient is financially responsible for all services. We are contracted with several insurance companies; it is your responsibility to make sure that our physician participates in your specific plan. In the event the patient's health plan denies coverage for any reason, the patient will be responsible for that payment in full. It is the patient's obligation to be familiar with their insurance co-payment and/or deductible amounts and amount must be paid in full at the time of visit.

(_____) Lapse of Coverage/ Self pay. For patients without coverage, our office will charge a flat fee of **$150.00**. The payment is due in full at the time of service and pricing may be subject to change.

(_____) Physical vs Office Visit. A "physical" or "preventive health exam" is a thorough review of your general well-being. An "office visit" is an appointment time to discuss new or existing problems. The distinction between a "physical" and an "office visit" is especially important when we submit a bill to your insurance company for that visit. If you don't specify when making the appointment that you would like a physical, then it will be scheduled as a regular office visit and you will have to make a new appointment to receive your physical.

(_____) Returned Checks There will be a $25.00 service fee for returned checks. If there are any acts of fraudulent behavior, the patient will be discharged from the practice.

(_____) Missed Appointments/ Same Day Cancellations The office requires a twenty-four (24) hour notice for an appointment to be deleted. In the event that we are not notified in advance, the patient will be charged a $25.00 "No-Show" fee. The fee must be paid prior to the patient's next office visit. After Three (3) No shows you will be discharged from the practice.

(_____) Courtesy We will make every effort to provide prompt on-time service, the healthcare needs of each individual do not necessarily lend themselves to an exact schedule. We therefore appreciate your understanding and patience. Angry or foul language directed to our staff regardless of the issues involved will absolutely not be tolerated and will be grounds for immediate dismissal from our practice. We're sorry if you ever have to wait! We consider your time just as important as ours, so we try hard to get scheduling right. We do find that at least one contribution to increased wait times is when patients bring multiple health issues to an office visit. Please try to limit your visit to the most pressing issues, and schedule a second appointment for additional concerns. All of that being said, we never truly know what patient needs will be or what emergencies may arise. And we need your help! If everyone arrives on time and is prepared for their appointment, it makes it run more smoothly for everyone else. Thanks!

(_____) Prescription Refills The issue of "medication refills" is often a sensitive one for patients. When people visit the office for a medication refill, it's really a follow-up on the medical condition, and intended with our patient's best interest in mind. A prescription medication is one that has the potential for complications and we believe the prescriber has a responsibility to supervise the patient. As such, we ask that you schedule an appointment to have your prescriptions filled. In some cases, we deem there to be too much risk to approve refills without seeing you first. This can even be true of maintenance medicine. Some medications are best monitored with laboratory testing in addition to an office visit. These include cholesterol lowering medication, blood pressure and diabetes medication, and thyroid supplements. If you think you may need lab work prior to the office visit.

(_____) Refills of prescription medications that fall under the general category of CONTROLLED SUBSTANCES will require a weekly visit due to the new federal guidelines. Please be aware that refills may take up to 72 hours to process, **so please plan accordingly**. Your refill request may be denied should you fail to comply with our policy.

(_____) Our doctor **MUST SEE YOU** prior to prescribing a new RX, refills on **Antibiotics or Narcotics (Controlled medications)** and changing your existing medication. **NO** controlled medication will be prescribed over the phone, out of State, after hours, or weekends.

(_____) If you have **not been seen** by the doctor within the past 6 months and need a refill, you must schedule an appointment for your prescription refill. If you are not able to and need to refill your routine Rx then we will send 30 days' supply only if you were seen in the last 6 months otherwise.

(_____) Test Results: Our office will only contact you if your tests are abnormal. A staff member will contact you if you need to take immediate action regarding your results. If the doctor needs to speak to you regarding your results, you will receive a phone call and be asked to schedule an appointment. If you wish to obtain a hard copy of your test results, please stop by our office and we will print them for you.

(_____) Messages & Referrals We will try our best to respond to your messages within a 24-hour time period. Remember that if the office is very busy, the doctor may not be able to call back for several hours, and if there is a question about whether you should be seen, it is often better to request an appointment. Likewise, due to the nature of insurance-based healthcare, please also allow **48 to 72 HOURS** to process your referrals. Unfortunately, at this time we are currently not offering pain management services. Patients who require this service will be referred by the doctor to pain management. If we refer you to pain management or any other specialist the patient will have one month to set up an appointment with the specialist. Failure to do so will lead to non-compliance and will be discharged from practice.

(_____) FMLA & Disability Forms We do require that FMLA Forms & Short-Term DISABILITY Forms be completed **IN PERSON** during our regular office hours, at which time our providers may refer you to appropriate specialists for further evaluation and management.

(_____) EMERGENCY OFFICE VISITS If our doctor is seeing you on Emergency Basis then please stay focused on the reason for that day's visit. The doctor is seeing you in between scheduled patients. We will take care of your immediate problem first and schedule your routine visit on another day. Your regular prescriptions will not be filled on your emergency visit.

(_____) WALK-IN Policy. We see our patients by appointment and do our best within the limits of circumstances that we can control, to see our patients on time. We feel that patients deserve our attention during the appointment time we have reserved for them. **We do not allow walk in appointments**, as it interferes with our ability to deliver safe medical care in a timely manner to all of our patients. To that end, we request that all patients call for an appointment time before coming to our offices. We DO have same day sick appointments available.

(_____) **Telephone Calls During Office Hours (Return Phone Calls)** Our offices have no specific "telephone hours." During regular office hours you may call to schedule an appointment or to obtain information. If you wish to discuss a problem or ask a question of the physician, the receptionist will take your name, your phone number, and a brief description of the problem. The physician will then return your call as soon as time allows. Remember that if the office is very busy, the doctor may not be able to call back for several hours, and if there is a question about whether you should be seen, it is often better to request an appointment.

(_____) OUTSTANDING BALANCE POLICY It is our policy that all past due accounts must be paid prior to making an appointment. If you are not able to pay balance in full, we will work with you to arrange a reasonable payment plan. If no resolution can be made, your account may be sent to the collection agency and possible discharge from the practice.

(_____) Automatic Discharge can occur if a patient has not been seen within the past 2 years. If that occurs you will be considered a new patient and will be scheduled accordingly. Other reasons for an automatic discharge are three no shows, abuse of staff, medications, facility, habitual noncompliance or anything deemed inappropriate behavior unfit for the practice. If dismissed for any of those reasons you will not be welcomed back to the practice.

Signature:_____ Date:_____

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Delaware Family Medicine to release my records and any information requested to the following individuals.

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

3. _____ Relation to Patient: _____

4. _____ Relation to Patient: _____

Authorization Regarding Messages (please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with _____.

_____ _____

Patient Name (PLEASE PRINT) Date

_____

Patient Signature