



## Atlantic Adult and Pediatric Medicine Confidential Contact Form

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
Email Address: \_\_\_\_\_ Gender: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Full time/Part Time/Student / Retired  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Emergency Contact Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_  
(C) \_\_\_\_\_

### INSURANCE

Please provide a copy of the front and back of your insurance card(s).

Subscribers Name (if different): \_\_\_\_\_

Subscribers Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship to patient: \_\_\_\_\_

Subscribers Address: (if different from above) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address of Insurance plan: \_\_\_\_\_

Phone: \_\_\_\_\_

Claims Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Claims Phone: \_\_\_\_\_ Group # \_\_\_\_\_

Member/Policy # \_\_\_\_\_

Do you have any secondary or additional Insurance plans? YES/ NO

Secondary Insurance Company: \_\_\_\_\_

Subscribers Name (if different): \_\_\_\_\_

Subscribers Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Relationship to Patient: \_\_\_\_\_

Subscribers Address: if different from above) \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Address of Secondary plan: \_\_\_\_\_

Phone: \_\_\_\_\_

Claims Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip: \_\_\_\_\_

Claims Phone: \_\_\_\_\_ Group # \_\_\_\_\_

Member/Policy ID # \_\_\_\_\_

By signing below, I verify that the above information is correct and true to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Atlantic Adult & Pediatric Medicine

Patient Consent for Release and Disclosure of Protected Health Information

I hereby give my consent for Atlantic Adult & Pediatric Medicine to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by Atlantic Adult & Pediatric Medicine describes such uses and disclosures more completely).

With this consent, Atlantic Adult & Pediatric Medicine may call or text my home or other alternative location and leave a message on voice mail, answering machine, or with a person in reference to any items that assist the practice in carrying out TPO. Such items include appointment reminders, insurance items, and any calls pertaining to my clinical care. Atlantic Adult & Pediatric Medicine may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, test results, and patient statements. With this consent, Atlantic Adult & Pediatric Medicine may also e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, test results, and patient statements.

I have been offered a written copy of the Notice of Privacy Practices of Atlantic Adult & Pediatric Medicine prior to signing this consent. Atlantic Adult & Pediatric Medicine reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices will be posted in the office or may be obtained by forwarding a written request to the Privacy Office, Atlantic Adult & Pediatric Medicine, 34435 King Street Row, Suite 1, Lewes, DE 19958.

I have the right to request, in writing, that Atlantic & Pediatric Medicine restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Atlantic Adult & Pediatric Medicine may decline to provide treatment to me.

\_\_\_\_\_(Initial) I was offered and received / declined a copy of the Notice of Privacy Practices.

I also give my consent to AAPM to disclose my health information to the following:

NAME: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

NAME: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

NAME: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of patient or legal guardian: \_\_\_\_\_

Relationship: \_\_\_\_\_

Internal Use Only:

If patient or patient's representative refuses to sign the Patient Consent for Use an disclosure of Protected Health Information, please document date and time the notice was presented to patient and sign below.

Presented on (date and time): \_\_\_\_\_ By (name & title): \_\_\_\_\_



**Atlantic Adult & Pediatric Medicine**

**Authorization for Treatment and Financial Agreement**

**Acknowledgement of Receipt of Privacy Notice**

I hereby apply for treatment by Atlantic Adult & Pediatric Medicine providers and/or their assistants. Such treatment may include medications, injections, x-rays, and other office procedures as they deem medically necessary.

Further, I authorize the filing of any and all insurance claims in-force, and request direct payment to Atlantic Adult & Pediatric Medicine of any amounts due. I understand that I am financially responsible for all charges not covered by my benefit plan and accept full responsibility for such charges. Regulations pertaining to medical assignment of benefits apply. I also understand that should my insurance plan require a co-pay, I am required to pay it on the day of service. Furthermore, if Atlantic Adult & Pediatric Medicine does not participate with my insurance plan or I am a self-pay patient, I am required to pay all charges on the day of service.

I further acknowledge that I have been offered a written copy of Atlantic Adult & Pediatric Medicine **Notice of Privacy Policies** detailing how my information may be used and disclosed as permitted under federal and state laws. I understand my rights as described in this notice. I also acknowledge that I received a copy of Atlantic Adult & Pediatric Medicine's Payment **Policy**.

I also permit a copy of this authorization to be used in place of this original.

If I do not sign this consent, or later revoke it, Atlantic Adult & Pediatric Medicine may decline to provide treatment to me.

Patient's Name:

\_\_\_\_\_ DOB \_\_\_\_\_

Signature:

\_\_\_\_\_ Date:

X If not patient, name & signature of legal guardian.

\_\_\_\_\_

Relationship to Patient

\_\_\_\_\_

Internal Use Only:

If patient or patient's representative refuses to sign the Authorization for Treatment and Financial Agreement/Acknowledgement of Receipt of Privacy Notice, please document date and time the notice was presented to patient and sign below.

Presented on (date & time): \_\_\_\_\_ By: (name & title): \_\_\_\_\_



**Atlantic Adult & Pediatric Medicine**  
**OFFICE POLICIES**

Katelin Haley, DO

Lisa Bartels, MD

Maggie (Kirsten) Pedersen, PA-C

Jessica Huston, PA-C

We look forward to providing you with the highest quality medical care and services to promote your overall wellness and efficiently access the healthcare you need. We greatly appreciate any feedback that you feel would help us serve you better.

- A 24-hour notice is required to cancel or reschedule an appointment. If you do not provide enough notice, a \$25 "No Show" fee for routine visits and \$50 for well child, annual physical, and annual wellness visits will be added to your account balance. This will be your financial responsibility and not that of your insurance company
- Arriving on time is essential to allow for adequate time and attention at your visit. If you arrive 15 minutes late for your appointment, you may be asked to reschedule.
- Insurance cards must be brought to every appointment and the office promptly notified of any changes. If you do not provide us with the correct billing information, you will be responsible for payment.
- Copayments and fees are due at the time of your visit. This is a contract between you and your insurance provider. If you are unable to pay your copayment or deductible at the time of your visit, your appointment will be rescheduled.
- All newborns must have active insurance by one month of age. If your child is insured by DE Medicaid, the child must have his/her own active ID. All other children need to be listed as covered on active policies. If the child does not have active coverage by one month of age, visits will be paid with cash or credit card only or the appointment will be rescheduled.
- The office will call, text and/or email you to remind you of your upcoming appointment. It is your responsibility to make sure that the office has updated phone numbers at all times. It is also your responsibility to remember appointment dates and times.
- After 3 (three) "No Shows" you will be discharged from the practice and a notice will be sent to your insurance company stating such.
- If anyone other than the parents or legal guardian brings a minor to the office for treatment, a written consent with proper insurance card and co-payment must be submitted.
- HIPAA privacy forms must be on file for each patient. This will allow us to share your health information only with who you decide. This will protect your privacy.
- There is a \$35 returned check fee.
- There is a \$25 fee for records. The office reserves the right to increase the fee based upon the length of the file copied.
- All referrals require 48 hours advance notice. We are not able to retroactively submit referrals. You must have been seen by our office within the past year for a referral to be issued.

- All prescription refill requests require 48 hour notice. Controlled substances will not be refilled via the on-call clinician and must be electronically prescribed.
- Please allow a minimum of 48 hours for all forms to be completed. Be advised that there will be a fee of \$10-\$25 for all forms that we are asked to complete.
- All fees, co-payments, and account balances must be paid in full prior to your visit, unless you are on a payment contract with the office.
- Messages will be returned within 24 hours (longer if weekends or holidays) in the order of urgency. Please do not make multiple calls, as this may delay our return call to you.
- Any person has the right to have a chaperone present during their examination. Parents or guardians may sign a waiver if the presence of a chaperone during a minor's examination is declined.
- We utilize telehealth (synchronous audio and video and audio alone) and portal messaging or digital consult visits (patient initiated secure portal message communication of health concerns that require medical decision making) in compliance with all state and federal regulations. You may be required to come to the office for an in-person exam after assessment by your physician or physician assistant. You are responsible for any copays or fees related to telehealth and portal messaging visits. This varies by individual insurance policy and you are encouraged to clarify coverage with your policy.
- We do not prescribe chronic opiate medications and will facilitate referrals to pain management for chronic pain control if needed. Prescribing of controlled substances is at the discretion of your physician and/or physician assistant and may require completion of a controlled substance agreement.

By signing this agreement, I am indicating that I have read, understand and agree to abide by the office policies listed on this form.

---

Print Name

---

Signature

---

Date



Atlantic Adult & Pediatric Medicine  
AUTHORIZATION FOR RELEASE  
OF INFORMATION

I hereby authorize the release of my health information as listed below:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Person or Institution authorized to receive information: Atlantic Adult & Pediatric Medicine, 34435 KING STREET ROW, SUITE ONE, LEWES, DE 19958

Phone Number: 302-644-1300 Fax Number: 302-644-1086

Person or institution authorized to send information: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Description of Information:

- Medical Record Abstract     Entire Record     Other \_\_\_\_\_

(Medical Record Abstract includes: Discharge Summary. Emergency Room Record. History and Physical, Laboratory Reports. X-ray, Report)

Special Records: Medical Records to be released will not include records of drug and alcohol abuse program treatment, mental health records or STD, HIV, or generic information records unless the specific boxes below are checked. This information is protected by special laws. Checking the boxes is not a representation that such information exists.

- Includes drug & alcohol records     includes HIV records     includes STD records  
 Includes genetic information     includes mental health records

Purpose of Release of Information:

- Personal Use     Medical Treatment/Management     Legal Proceedings  
 Employment Related Purposes     Insurance Related     Other \_\_\_\_\_

1. This authorization will expire: Event: \_\_\_\_\_ One Year \_\_\_\_\_  
Date: \_\_\_\_\_

Unless otherwise specified, this authorization will expire one year after the date of this request.

- I understand that I may revoke this authorization at any time by notifying AAPM Privacy Coordinator in writing at 34435 King Street Row, Suite 1, Lewes, DE 19958. I understand that revocation will not have any effect on actions AAPM took before they received this revocation.
- This authorization is voluntary. I understand that my treatment or payment for services will not be affected if I do not sign this authorization.
- I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the information may no longer be protected by federal privacy regulations.

Signature of Patient or Patient's Representative. Date      Printed Name of Patient's Representative      Relationship to Patient

To recipient: Information regarding drug and/or alcohol use, abuse, treatment or referrals for treatment has been disclosed to you from records protected by Federal confidentiality rules (43CFR part 2). The federal rule prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.