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
34435 King Street Row, Suite 1
Lewes, DE
302-644-1300 Fax: 302-644-1086

Atlantic Adult & Pediatric Medicine
Patient Health Information

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

Preferred way to be addressed/Nickname: _____

What is the reason for your visit today?_____

Name(s) of other doctors you see and why:_____

_____

Name and locations of pharmacy you use _____

Personal Medical History:

___ Asthma
___ Allergies
___ Anemia
___ Anxiety or Panic Disorder
___ Arthritis
___ Cancer (type: _____)
___ Cirrhosis
___ Coronary artery disease (ex heart attack)
___ COPD/Emphysema
___ Cholesterol
___ Clotting disorder/blood clots
___ Depression
___ Diabetes
___ Fibromyalgia/Chronic Pain
___ GERD/Acid reflux
___ High Blood Pressure
___ Hepatitis/Liver disease
___ HIV/AIDS
___ Kidney Disease
___ Migraines/headaches
___ MRSA
___ Pregnancy Complications
___ Osteoarthritis
___ Rheumatologic/Autoimmune disease
___ Stroke
___ Seizures
___ Urinary issues
___ Sexually transmitted infection
___ Thyroid disease
___ Urinary issues

List any other problems you are currently being treated for that are not listed above.

_____

_____

PREVENTIVE CARE:

When was your last:
Mammogram_____
Pap smear_____
Colonoscopy_____
Osteoporosis screening/bone density test_____
Flu vaccine_____
Other vaccines _____

HOSPITALIZATIONS: If you have ever been hospitalized for any serious medical illness or operation, please list below the year & reason for hospitalization:

1. _____
2. _____
3. _____
4. _____

SURGICAL HISTORY:
List all surgeries with dates of procedure:

1. _____
2. _____
3. _____
4. _____

Have you ever had problems with anesthesia? Yes No
If yes, what problems? _____

SOCIAL HISTORY

Relationship/Marital Status: Single Married Partner Widowed Divorced/Separated
Name of partner/spouse if applicable: _____
Do you identify as:___ straight ____ gay ___ lesbian ___ bisexual ___ other
Sexually active? Yes / No Birth control or contraception method: _____
Do you have any concerns about your sexual health? _____
Do you feel safe at home? Yes / No
Diet preference _____
Exercise habits _____
Tobacco Use or exposure? If so, describe, _____
Do you drink alcohol? Yes / No How much per week _____
Do you use drugs for non-prescription reasons? (Marijuana, cocaine, heroin, etc.) Yes / No
Have you been treated for drug or alcohol dependence? Yes / No
Occupation_____Currently employed: Yes / No
Household members_____ Pets _____

ALLERGIES

Please list all known allergies to drug, food, or other allergen and type of reaction
Drug/Allergen Reaction

_____
_____
_____

MEDICATIONS

List ALL medications you take: (use back of paper if you need more room)

Name of Medication Dose Frequency How long have you been taking?

_____
_____
_____
_____
_____
_____

Do you take any vitamins, supplements, or over the counter medicines (including tylenol, ibuprofen, aleve, etc)? Yes / No
If yes, which one(s)? _____
_____

FAMILY HISTORY

Please circle all that apply. Family includes your parents, children, siblings, aunts and uncles related by blood.

Coronary Artery Disease/Heart attack
High Blood Pressure
Stroke
Cancer (type_____)
Depression/anxiety/bipolar disorder
Kidney Problems
Bleeding Disorder
Dementia/Alzheimer Disease
Elevated Cholesterol
Diabetes
Blood Clot
Thyroid problems
COPD/Emphysema
Genetic Disorder
Liver Disease
Other: _____
_____

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 may 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: _____

Signature: _____ Date:_____

In not patient, name of 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): _____

Revised 07/30/2020

Atlantic Adult & Pediatric Medicine

OFFICE POLICIES

Katelin Haley, DO Tracie Crone, PA-C

We look forward to providing you with the highest quality medical care and services to promote you 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 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 any the office promptly notified of any changes. If you do not provide us with the correct billing information, you will be responsible for payment.
- Co-payments 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 co-payment 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 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 may require you to present to the office for prescription pickup. Only those on a patient's HIPAA privacy form will be allowed to pick up prescriptions for a patient.

- Please allow 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) for visits 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 provider. You are responsible for any copays or fees related to telehealth 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 provider 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:

O Medical Record Abstract O Entire Record O 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.

O Includes drug & alcohol records
O Includes genetic information records
O Includes HIV records
O Includes mental health records
O Includes STD records

Purpose of Release of Information:

O Personal Use
O Employment Related Purposes
O Medical Treatment/Management
O Insurance Related
O Legal Proceedings
O Other_____

1. This authorization will expire: Date:_____ Event:_____ One Year_____

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

2. I understand that I may revoke this authorization at any time by notifying AAPM Privacy Coordinator in writing al 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.
3. This authorization is voluntary. I understand that my treatment or payment for services will not be effected if I donot sign this authorization.
4. 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 lo 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.