SEAFORD INTERNAL MEDICINE, LLC
D.C. MEDICAL SERVICES, LLC

Board Certified Internal Medicine/Infectious Diseases

PATIENT INFORMATION

Patient Name: ______________________ **Date:** ____________
Street Address: ______________________
City: ____________ **State:** ________ **Zip Code:** ____________
Social Security #: ____________ **Date of Birth:** ________ **Marital Status:** ____________ **Sex: M F**
Home Phone #: ____________ **Work #:** ____________ **Cell #:** ____________
Employer: ______________________ **Occupation:** ______________________
Emergency Contact: ______________________ **Relation to Patient:** ______________________
Home Phone #: ____________ **Work #:** ____________ **Cell #:** ____________
Pharmacy Name: ______________________ **Location:** ______________________
Email Address: ______________________

Guarantor Information: If Other Than Patient (Required if patient is a minor/dependent)

Guarantor Name: ______________________ **Relation to Patient:** ______________________
Street Address: ______________________
City: ____________ **State:** ________ **Zip Code:** ____________
Social Security #: ____________ **Date of Birth:** ________ **Marital Status:** ____________ **Sex: M F**
Home Phone #: ____________ **Work #:** ____________ **Cell #:** ____________

Insurance Information

Primary Insurance: ______________________ **Effective Date:** ____________
Policy Holder Name: ______________________ **Relation to Patient:** ____________
Social Security #: ____________ **Date of Birth:** ____________ **Copay: $** ____________
Secondary Insurance: ______________________ **Effective Date:** ____________
Policy Holder Name: ______________________ **Relation to Patient:** ____________
Social Security #: ____________ **Date of Birth:** ____________ **Copay: $** ____________

Authorization for the Release of Medical Information/Assignment of Benefits

I give permission to ***Seaford Internal Medicine, LLC (SIM)/D.C. Medical Services, LLC (DCMS)*** and its employees, agents and medical providers to release medical information to insurance carriers, 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 ***SIM/DCMS*** or appropriate provider. 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 my medical information may be electronically submitted to any or all treating physicians, hospitals and/or health care entities.

X____

Signature **Relation to Patient** **Date**

SEAFORD INTERNAL MEDICINE, LLC
D.C. MEDICAL SERVICES, LLC
Board Certified Internal Medicine/Infectious Diseases

MEDICAL HISTORY

Patient Name: ______________________________ **Age:**________ **Date:** ______________

Chief Complaint: ____

History of Present Illness: ____

____

____

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ **No** ☐ **Yes**
(If yes, please list names of medicine and type of reactions):

____

____

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

Please circle if you have had problems with or are presently complaining of any of the following:

1. Abdominal discomfort
2. Alcohol abuse
3. Anxiety
4. Anemia
5. Arthritis
6. Asthma
7. Blood disorders
8. Blood in stool
9. Bronchitis
10. Cancer
11. Change in bowel habits
12. Chest pain/chest Tightness
13. Colitis
14. Constipation
15. Depression
16. Diabetes
17. Diarrhea
18. Difficulty urination
19. Drug abuse
20. Frequent urination
21. Gall bladder disease
22. Gout
23. Hay fever
24. Headache
25. Head or neck radiation
26. Heart disease
27. Hemorrhoids
28. Hepatitis or jaundice
29. High blood pressure
30. Indigestion
31. Kidney diseases
32. Kidney stones
33. Lightheadedness
34. Low back pain
35. Nausea
36. Palpitations
37. Persistent
38. Pneumonia
39. Rheumatic fever
40. Skin diseases
41. Shortness of breath
42. Swollen ankles
43. Thyroid disease
44. Tuberculosis
45. Ulcers
46. Unexplained weight gain/loss
47. Venereal diseases
48. Vomiting
49. ________________
50. ________________

____

____

____

____

____

____

Gynecologic and Obstetric History

Age at onset of periods: ____________ Frequency: __________________ Length of period: ____________

Pregnancies: ______________ Births: ______________ Miscarriages: ______________

Prolonged or abnormal bleeding: ☐ No ☐ Yes (Please Describe): ____________________

Leakage of urine: ☐ No ☐ Yes (Please Describe): ____________________

Pelvic pain: ☐ No ☐ Yes (Please Describe): ____________________

Abnormal discharge: ☐ No ☐ Yes (Please Describe): ____________________

History of abnormal Pap smear ☐ No ☐ Yes (Type of treatment): ____________________

SEAFORD INTERNAL MEDICINE, LLC
D.C. MEDICAL SERVICES, LLC
Board Certified Internal Medicine/Infectious Diseases

MEDICAL HISTORY

Please List and Supply the Dates of:

Operations: ______________________ ______________________ ______________________

______________________ ______________________ ______________________

Hospitalizations other than for surgery: ______________________ ______________________

______________________ ______________________ ______________________

Immunization history—have you had: **Pneumovax immunization?** ☐ No ☐ Yes **When?** ____________

Hepatitis B? ☐ No ☐ Yes **When?** ___ **Flu immunization?** ☐ No ☐ Yes **When?** ____________

Other? __________ ☐ No ☐ Yes **When?** _____ **Tetanus immunization?** ☐ No ☐ Yes **When?** ____________

When was your last:

Pap smear? ________________ Breast exam? ____________________ Stool check for blood? ________________

Mammogram? ______________ Cholesterol check? ______________ Prostate exam? ______________________

FAMILY HISTORY

Has any members of your family (including parents, grandparents, and siblings) ever had the following?

Illness		Which family members?	Approx.. age when diagnosed
Cancer (describe type)	☐ No ☐ Yes		
Hypertension (High blood pressure)	☐ No ☐ Yes		
Heart disease	☐ No ☐ Yes		
Diabetes	☐ No ☐ Yes		
Strokes	☐ No ☐ Yes		
Mental disease (anxiety, depression, etc.)	☐ No ☐ Yes		
Drug or alcohol addiction	☐ No ☐ Yes		
Glaucoma	☐ No ☐ Yes		
Bleeding diseases	☐ No ☐ Yes		

Other:____

MEDICATIONS (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose

PREVENTIONS

Do you wear seatbelts?	☐ No ☐ Yes	If no, why not? ______________________
Do you wear a bike helmet?	☐ No ☐ Yes	☐ N/A
Do you smoke?	☐ No ☐ Yes	If yes, how many packs per day? ______________
Do you drink alcoholic beverages?	☐ No ☐ Yes	If yes, how much per week ____________
Do you drink coffee?	☐ No ☐ Yes	If yes, how many cups per day? ____________
Do you drink tea?	☐ No ☐ Yes	If yes, how many cups per day? ____________
If there is a gun in your home, is it out of children's reach and unloaded?	☐ No ☐ Yes	☐ N/A
Do you use drugs? (marijuana, cocaine, crack, etc.)	☐ No ☐ Yes	If yes, explain: ________________
Have you ever engaged in any activity which has put you at risk of getting AIDS?	☐ No ☐ Yes	If yes, explain: ________________
Do you wish to be tested for AIDS?	☐ No ☐ Yes	
Have you ever worked with chemicals, paints, asbestos, or other hazardous material?	☐ No ☐ Yes	If yes, explain: ________________
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	☐ No ☐ Yes	
Do you ever feel afraid of your partner?	☐ No ☐ Yes	
Do you have a "living will"?	☐ No ☐ Yes	
Do you have a donor card?	☐ No ☐ Yes	

Method of birth control? ____

SEAFORD INTERNAL MEDICINE, LLC
D.C. MEDICAL SERVICES, LLC
Board Certified Internal Medicine/Infectious Diseases

Statement of Receipt of Privacy Practices
Patient Consent for Use, Treatment, and Disclosure of Protected Health Information

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

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

With my consent, D.C. MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC may disclose my PHI to the following individuals (family, relatives, or friends) who may assist in my care:

Name	Relationship	Home Phone #:	Work Phone #:	Cell Phone #:

I have the right to review the *Notice of Privacy Practices* prior to signing this consent. D.C. MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC reserves the right to revise its *Notice of Privacy Practices* at any time. A written copy of our *Notice of Privacy Practices* may be obtained by forwarding a written request to our office.

<u>CONSENT FOR CALLS TO HOME and TEXTING:</u> With my consent, D.C. MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC may call my home or other designated location and leave message on my voicemail or with a person in reference to any item that may assist D.C. MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

<u>CONSENT FOR MAIL:</u> With my consent, D.C. MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC may mail to my home or other designated location any item that may assist D.C. MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC in carrying out TPO, such as appointment reminder cards and patient statement as long as they are marked CONFIDENTIAL.

<u>CONSENT FOR E-MAIL:</u> With my consent, D.C. MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC may e-mail to my designated e-mail address, any message in reference to any item that may assist in my care. D.C. MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, 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 how D.C. MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC restricts, uses, or discloses my PHI to carry out the TPO. However, D.C. MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, 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 D.C. MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC's use and disclosure of my PHI to carry out TPO.

I understand that, under 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 multiple healthcare providers who may be directly and indirectly involved in my treatment
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I may revoke my consent in writing, except to the extent that D.C. MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC has already made disclosure in reliance upon my prior consent. If I do not sign this consent, D.C. MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC may decline to provide services to me.

Signed by: ____ ______________________________
Patient's Name Date of Birth

____ ______________________________
Signature of Patient or Legal Guardian Date of Signature

____ ______________________________
Printed Name of Patient or Legal Guardian Relationship to Patient

(PATIENT/GUARDIAN WILL BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION)

SEAFORD INTERNAL MEDICINE, LLC
D.C. MEDICAL SERVICES, LLC
Board Certified Internal Medicine/Infectious Diseases

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name:	**DOB:** (MM/DD/YYY)	**SSN:**

Individual or entity authorized to provide information:

Individual or entity authorized to receive information:

Description of information authorized to be disclosed:

Purpose of disclosure:

If transferring out, please provide a brief explanation:

Description of information you DO NOT authorize to be disclosed (*subject to provider's approval*):

Method of disclosure:

______ Pick Up **Name of individual: ____**
______ Fax **Fax Number: ____**
______ Mail **Name: ____**
Address: ____

Patient Acknowledgement

By signing below, I certify that:

- I understand that I may inspect a copy of the records being disclosed.
- I understand that this authorization will expire in 3 months following the date of this authorization.
- I understand that I may revoke this authorization at any time *(except to the extent that the information was already disclosed on reliance to this signed authorization)* by notifying the provider's office in writing.
- I understand that if the person or organization that receives this information is not covered by privacy regulations, the information may be disclosed and would no longer be protected.
- I understand that there may be a fee for copying/supplying medical records.
- I understand that I have a right to receive a copy of this form.
- I understand that photo ID is required if the medical records are being picked up by another individual.
- I understand that I will be contacted at the following phone number when records are ready for release:

Preferred contact number: ______________________
Will not expire until notified by patient.

____ ________________________________
Signature of Patient or Patient Representative **Date**

____ ________________________________
Patient's Name (Please Print) **Relationship to Patient**

SEAFORD INTERNAL MEDICINE, LLC
D.C. MEDICAL SERVICES, LLC
Board Certified Internal Medicine/Infectious Diseases

PATIENT CENTERED MEDICAL HOME

DCMS/SIM 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 where physicians can access your electronic medical records.
- ✓ Our on-call physicians are available to speak with after-hours for urgent needs 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 (Please Print) Date of Birth (MM/DD/YYYY)

____ ____________________

Signature of Patient or Patient Representative Date

PRACTICE CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that you provide the office more than 24 hours notice. This enables the availability of the appointment slots to other patients in need of care.

Patients who do not show up for their appointment without notifying the office, will be considered a "**NO SHOW**," which will be documented in their chart and with their provider. Patients who No Show will receive a No Show Letter emphasizing the importance of keeping scheduled visits and the ramifications of failing to keep future appointments. Patients who continue to No Show after their initial letter, two or more times within a 12-month period, are subject to be discharged from the practice and will be denied any future appointments.

We understand that unavoidable circumstances may cause you to cancel less than 24 hours prior to your appointment; therefore, penalty in these instances are based on provider and management discretion. Our practice firmly believes that good physician/patient relationships are based upon understanding and clear communication.

Please sign below acknowledging that you have read, understand, and agree to the cancellation and no show terms above.

Patient Name (Please Print) Date of Birth (MM/DD/YYYY)

Signature of Patient or Patient Representative Date

IQHealth

Welcome to your Secure Patient Portal!

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.

....

I wish to participate

Patient Name (Please Print) ______________________ Date of Birth (MM/DD/YYYY) ______________________

E-mail Address ______________________ Last 4 Digits of SSN ______________________

I do not wish to participate

Patient Name (Please Print) ______________________ Date of Birth (MM/DD/YYYY) ______________________

SEAFORD INTERNAL MEDICINE, LLC
D.C. MEDICAL SERVICES, LLC
Board Certified Internal Medicine/Infectious Diseases

PRACTICE OFFICE POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them on your/child's behalf. **If the insurance company *that* you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan.**

2. If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for the visit. If your insurance is through an auto accident you must provide the office with the name of the insurance company, the claim number, the adjustors name and phone number, and any information pertaining to this. You are also responsible for completion of the PIP application.

3. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.

4. You are responsible for any balance on your account. All self-pay patients are required to pay the **full balance** at the time of visit. **All copays, deductibles** and balances are required to be paid at time visit. If you do not have copay, you will be asked to reschedule your appointment.

5. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered. It is also your responsibility to confirm that a prior authorization has been processed.

6. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.

7. If you have no insurance, payment for an office visit is to be paid at the time of the visit.

8. Co-payments are due at time of service. A $5.00 processing fee (or service fee) will be charged in addition to your co-payment if the co-payments is not paid at time of service or by the end of the next business day.

9. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 10 business days of your receipt of your bill.

10. If previous arrangements have not been made with our finance office; any balance over 90 days will be forwarded to a collection agency. The office will be contacting you by phone and will be leaving a message if you are not available. You will be responsible for collection fees and charges including the 30% being charged by the collection agency.

PRACTICE OFFICE POLICY

11. If you participate with a high-deductible health plan, we require a copy of the health savings account debit/credit card or a personal credit card remain on file. There are addenda to this financial policy, which are signed separately.

12. We require 24-hour notice for canceling any appointment or a $25 fee will be charged.

13. A $25 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

14. We charge a fee for copy or transfer of medical records. There is a fee for any forms completed. Payment is due when the forms are dropped off. We have a 3-5 day turnaround time for forms.

15. Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days. It is your responsibility to know if a selected specialist participates in your plan. Remember your primary care physician must approve referrals before being issued.

16. Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. Not all plans cover annual healthy physicals or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of visit.

17. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

18. We accept cash, checks, MasterCard, Visa, Discover and debit cards.

19. All non-emergency messages for the doctors are reviewed at the end of the day after the doctors have finished seeing patients.

20. All controlled substances and antibiotics will require an appointment for each and every refill. No controlled substances or antibiotics will be dispensed without an appointment. There will be no exception regarding this policy.

I have read and understand the office policy and agree to comply and accept the responsibility for any payment that becomes due, as previously outlined.

_______________________________________ _______________________
Patient Name (Please Print) Date of Birth (MM/DD/YYYY)

_______________________________________ _______________________
Signature of Patient or Patient Representative Date