Preventive
PRIMARY CARE

Wilmington Office
701 Foulk Road, Suite 1A
Wilmington DE 19803

Newark Office
G-39 Omega Drive
Newark, DE 19713

Glasgow Office
2600 Glasgow Ave, Ste 103
Newark, DE 19702

Phone (302) 722-6615 Fax (302) 722-9010

PATIENT INFORMATION SHEET

Patient Name: _____ Date: _____

Address: _____City: _____ State: _____Zip: _____

Apartment/Unit: _____ Date of Birth: _____

Social Security No: _____-_____-_____ Gender: _____ Male _____ Female

Marital Status (circle one): Married Single

Home Phone: _____-_____-_____ Work Telephone: _____-_____-_____

Cell Phone: _____-_____-_____

Ethnicity (circle one): Hispanic/Latino Not Hispanic/Latino Other Declined

Who may we contact in case of an emergency?

Name: _____Phone Number: _____-_____-_____ Relation:_____

How did you hear about Preventive Primary Care?

O Friend O Family Member O Primary Care Physician O Cecil Whig O News Journal
O Other_____

WHAT YOU NEED TO KNOW

Read this notice, so you can make an informed decision about your care.
Ask us any questions that you may have after you finish reading.

I request that payment of authorized Insurance company benefits be made directly to Preventative Primary Care on my behalf for any services furnished to me by the party who accepts the assignment/physician. Regulations pertaining to Insurance assignment of the benefits apply.
Patient Signature: _____ Date: _____

I give Preventative Primary Care authorization to release information to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Insurance Company claims. I understand that any or all of my medical information may be used for blinded-data research, in which none of the data will be linked to my identity. I understand that my medical information may be electronically submitted to any or all of my treating physicians, hospitals and/or medical benefits to the party who accepts the assignment. If it is needed to provide my medical care, I grant permission for Preventative Primary Care to view my prescription history as made available by PDMP.

Patient Signature: _____ Date:_____

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Patient Name: _____

DOB: ___/___/_____

Medications:

If you have a list, please provide it to the office staff upon arrival.

Pharmacy Name: _____ **Phone Number:** _____

MEDICATION NAME	MG	HOW OFTEN YOU TAKE IT

Medication Allergies:_____

Family History:

Mother:

- ❑ Heart disease
- ❑ High Blood Pressure
- ❑ Heart attacks
- ❑ Cancer; What kind _____ _____
- ❑ Diabetes
- ❑ Stroke
- ❑ Other _____

Father:

- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Heart attacks
- ❑ Cancer; What kind _____ _____
- ❑ Diabetes
- ❑ Stroke
- ❑ Other _____

Medical History:

- ❑ Thyroid Illness
  - ❑ Hyperthyroidism

- ❑ Hypothyroidism
- ❑ Colonoscopy; If so, what year _____
- ❑ EGD; If so, what year _____
- ❑ Heart disease
- ❑ High Blood Pressure
- ❑ Cancer; If so, what type _____
- ❑ Diabetes
  - ❑ Type I
  - ❑ Type II
- ❑ Stroke
- ❑ Major Surgeries; please write the type of surgery and the date it was done
  - ❑ _____
  - ❑ _____
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ Other _____

Alcohol Use: ❑ YES ❑ NO

Are you a smoker: ❑ YES ❑ NO

Electronic Cigarette/ Vaping: ❑ YES ❑ NO

Substance abuse: ❑ YES ❑ NO

EMPLOYMENT/SCHOOL:

- ❑ Employed
- ❑ Part Time
- ❑ Retired
- ❑ Disabled
- ❑ Unemployed
- ❑ Student
- ❑ Unemployed

Home/Environment

- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Widowed

EXERCISE:

- ❑ FREQUENCY:
  - ❑ Never
  - ❑ Daily
  - ❑ 1-2 times a week
- ❑ EXERCISE TYPE:_____

Payment Policy

Thank you for choosing Preventative Primary Care as your healthcare provider. We are committed to providing you with quality and affordable health care. This policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

Insurance Coverage: We participate with most major insurance companies including Medicare and Medicaid. If we do not participate with your insurance company then payment is due at time of service. It is your responsibility to know and understand your insurance benefits. Please contact your insurance company should you have questions.

Proof of Insurance: All patients must provide a photo ID along with their insurance card. Failure to provide this information could result in non-payment of claims and become the patient balance. You are responsible for notifying us, prior to your visit, of any changes in insurance.

Referrals and Authorizations: Some insurances require a REFERRAL from your Primary Care Physician which you are responsible for providing at time of service. Some insurances require an AUTHORIZATION prior to services being rendered. Although we obtain the necessary authorization, it is not a guarantee of payment.

Copayments: Copayments are due at time of service. Failure to collect copayments constitute insurance fraud under federal and state regulations. For your convenience we accept cash, checks, Visa, MasterCard and Discover. If you do not pay your copayment your appointment may be rescheduled. A $10.00 service charge will be assessed each time a copay is not paid at time of service.

Patient Balances: All patient balances are due in full at time of service or immediately upon receipt of a statement. If payment is not made or a payment plan has not been established, then future services may be suspended. After 120 days the balance will be considered delinquent and may be forwarded to a collection agency. You will be charged a fee for any balances sent to collections. Should that occur you may be discharged from the practice. If discharged, you will receive written notification and have 30 days to find alternative care.

Missed Appointments: Appointments which are not cancelled within 24 hours prior to the scheduled time are considered a “no-show”. We charge a fee for no-show appointments. Based on circumstances we may extend a one-time courtesy. However, you will be charged for future occurrences.

Claim Submission: We file both primary and secondary claims. Once all insurance has been processed, any remaining balances will become the patient’s responsibility. We will make every effort to insure that your claims are processed and paid correctly. However, you may need to contact your insurance company directly.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand this payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

Advance Beneficiary Notice of Non-Coverage (ABN)

Note: If your insurance carrier does not pay for any services rendered by the provider, you will be responsible for the balance of the fees. Primary Health Insurance does not pay for every service provided, including some care that you or your healthcare provider have good reason to think you need. The provider of service will submit all claims to the insurance carrier(s) listed below in an attempt to obtain an official decision on payment. However, if the insurance carrier(s) does not pay for services rendered, then the healthcare provider is not liable.

Your health information will be kept confidential. If a claim is submitted to the insurance carrier(s), your health information on this form may be shared with the payor as per federal guidelines.

Primary Insurance: _____ Member ID or Policy #: _____

Group #: _____ Policy Holder Name: _____

DOB: ____/_____/_____ Does your insurance require a referral? _____Yes _____NO Copayment: $_____

Secondary Insurance: _____ Member ID or Policy #:_____

Group #: _____ Policy Holder Name: _____

DOB: ____/_____/_____

Third Insurance: _____ Member ID or Policy #:_____

Group #: _____ Policy Holder Name: _____

DOB: ____/____/_____

***Medicaid does not pay for all your healthcare costs. Medicaid only pays for covered tests and services when Medicaid rules are met, based on your coverage program. If you are enrolled in a limited coverage program, you may be billed for non-covered services. Limited coverage guidelines apply.*

Medicaid Full/Limited Coverage Programs include:

○ *Full coverage*	○ *Family planning and related services*
○ *Chronic Renal Disease Program*	○ *Qualified Medicare Beneficiary*
○ *DE Healthy Children's Program*	○ *Long Term Care*
○ *DE Prescription Assistance*	○ *Hospice*
○ *DE Cancer Treatment Program*	○ *Transportation*

- ***Health Options (Blue Cross Blue Shield) and Amerihealth Caritas***

******Patient eligibility will be verified by the Healthcare Provider's Office******

Additional information: *Signing below means that you have received a copy of this notice and understand its contents.*

Patient signature: _____ Date: _____/_____/_____

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Telephone (302) 722-6615 Fax (302) 722-9010

HIPAA (Health Insurance Portability & Accountability Act of 1996)
Acknowledgement of Privacy Practice Notice from
Preventative Primary Care

By my signature below, I acknowledge receipt of the **HIPAA Privacy Practice** notice for Preventative Primary Care::

_____ _____

Patient Name **Patient Signature**

_____

Date

If you have any questions about this notice or if you think we may have violated your privacy rights, please ask to speak to our **HIPAA Privacy Officer** or the office manager.
Please indicate below if you wish to retain a copy of this Privacy Practice Notice for your records and one will be provided.

Please circle one:

Yes

No

(Stop Here)

THIS SECTION FOR OFFICE USE ONLY

The above named patient and/or representative has declined to sign the acknowledgement of receipt of the Privacy Practice Notice from Preventative Primary Care.

_____ _____

Employee Name **Date**

Wilmington
701 Foulk Rd, Suite 1A

Omega
39 Omega Drive

Glasgow
2600 Glasgow Ave, Suite 103

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PATIENT PORTAL NOW AVAILABLE!!!

Preventative Primary Care would like you to join our new patient portal. Through the portal, you can:

- Send and receive non-urgent messages
- Request medication refills
- View lab and test results
- Request appointments and view scheduled appointments

Joining is easy. Simply supply your information below and you will receive an email invitation from IQHealth. The invitation expires in 90 days so please do not delay. Follow the link provided in the email to accept your invitation and create your account. When prompted for your shared secret, please enter your 5-digit zip code.

Name: _____ Date: _____

Date of Birth: _____

Email Address: _____

Trouble accepting the invitation or creating your account? If so, call Patient Portal Support: Cerner Client Care 1-877-621-8014