Over Thirty Years of Caring for our Patients

"Caring, Comfortable and Friendly Visits EVERYTIME"

Wagner & Prigg
Family Medicine
16529 Coastal Highway Lewes, DE
Phone: 302-684-2000
Fax- 302-645-6832

Jennifer Hurd, M.D
Catherine DeLuca, M.D.
Brian Prigg P-C PhD
Robert Barwick, PA-C
Jennifer Shade, NP
Susan Parks, FNP-BC
Charles G. Wagner, M.D.
Retired

TO: Our New Patient.

To care for your health we need to have as much of your past medical history as possible. We know this packet has many forms to fill out, however the information we need is important medically and/or we are required to have it in your file by State or Federal regulations.

Please complete this New Patient packet as soon as possible and return it to the practice **along with this face sheet with the following question answered.**

- ☐ I am a patient of Dr. DeLuca's who was previously seen at MidAtlantic Family Practice
- ☐ I am a patient of Susan Parks, FNP-BC who was previously seen at Clinic By The Sea.
- ☐ I am a new patient to Wagner & Prigg never seen by any of their providers before.

Please understand, the first visit may be more expensive than others might be in the future. This is due to obtaining and entering past medical records, and ordering preventative/diagnostic imaging and/or lab work. Your insurance may or may not pay these charges based on the type of benefits and the deductible you have with your insurance company.

Thank you.

Respectfully.

Bruce W. Truitt
Practice Manager
Wagner & Prigg Family Medicine
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To our new patient(s):

We would like to take this time to welcome you to our practice and to our Providers and Staff. Our providers have over 80 years of medical experience in Family or Primary Care, however they still will communicate between themselves, if necessary, to come up with the best health care plan for you.

We want you to feel comfortable when you have an appointment, so we have designed our practice model to give you a friendly and comfortable atmosphere. We realize we are not perfect, and sometimes due to unforeseeable circumstances, such as being short staffed due to vacation or illnesses, we may fall short of our goal. However, please understand when we find we have a problem we look for better ways to make things work. We require for our patients to fill out this patient packet before scheduling them for an appointment, so that they have plenty of time to correctly and completely fill out the information.

Please take time to read Wagner & Prigg Family Medicine's Patient Policies and fill out the following forms so that we may have as much of your past medical history as possible. The more we know about the medical problems you have had in the past, the better we will be able to prepare a Health Care Plan for you.

Please plan to arrive fifteen minutes early to complete the registration process the first time you visit us.

Please remember to bring:

- If you have insurance bring your insurance card(s), Medicare patients please bring the new MC card if they have received it in the mail.
- We will need picture identification, a driving license will do.
- Please either bring a list of medications that you take or just bring the medications in so we can take the Information off the container.
- If your insurance requires you to pay a co-pay, we will need to collect the copay at the beginning of the visit at the Check In window.
- If you do not have insurance, you will need to pay at the time of the visit, if you have no insurance you will receive a 20% discount when paying the balance at the time of visit.
- We will not write for controlled narcotics at the first visit, and not until we receive medical records from the prescribing physician.

Thank you for selecting our practice.

Jennifer Hurd, M.D.
Catherine DeLuca, M.D.
Brian Prigg, PA-C PhD
Robert Barwick, PA-C
Susan Parks, FNP-BC
Jennifer Shade, NP

WAGNER & PRIGG FAMILY MEDICINE

PATIENT POLICY LIST

>>>>PLEASE KEEP THESE NEXT TWO PAGES FOR YOUR USE <<<<

- **Scheduling Hours** Monday thru Friday
  - 8:00 a.m. – 11:45 am
    1:30 p.m. – 4:30 P.M

All of our providers are not available every day of the week for the above hours, however these are the hours at least one provider is scheduling patients and if you are sick or injured we will offer you an appointment in the same day or within 16 hours.
Our "office" is open Monday through Friday 8:00 am – 5:00pm.

- **Co-pays, Co-Insurance, Self-Pay (Non-insured)**

  - All co-pays are due when the patient checks in for their appointment.
  - We ask that Medicare Co-insurance be paid at Check Out unless the patient has a cross-over or MediGap supplemental insurance.
  - We also ask that Insurance deductibles for Medicare and commercial insurances be paid at the time of check out if known, many supplemental insurances do not cover the deductible of the Primary Insurance.
  - Self-Pay Patients –The balance is due at the time of visit, unless payment arrangements have been made by the billing staff, if paid at the time of the visit a 20% discount will be given.
  - Patients Owing a Balance on their account must pay at the time of Check-In before seeing the Provider, unless payment arrangements have been made with the billing staff.
  - *Patients owing an outstanding balance that has been billed three times will have a $10.00 Past Due charge for the next invoice and each month after and no appointments will be scheduled until the balance has been paid or a payment plan created.*

- **Appointments**
    - **Wagner & Prigg Family practice has an automatic notification system which will call your primary phone number, leave a message if you have voice mail and also text you about your upcoming appointment.   You may also confirm or cancel your appointment if you answer the incoming phone call.**

        - **Acute Problems** – If calling in the morning we will make every effort to offer you an appointment with your provider or one of our other providers the same day. If calling after 12:00 p.m. we will attempt to see you that afternoon, if not we will offer an appointment for the next morning. *We will offer you an appointment to be seen by your provider or another one of our providers, it is your responsibility to make time to get to the appointment offered.*

        - **New Problem, Non-Acute Appointments** – Will be scheduled within two weeks. (Skin Lesions, aches, etc.) To be at the discretion of the Office Staff.

        - **Follow-up appointments** – generally scheduled after you have had any diagnostic test, unless changed by the Provider to be scheduled earlier.

        - **Missed Appointments – We would like all of our patients to understand, we put aside a time period for their appointment, if they do not show up, another sick patient could have been scheduled in their time slot.**

            - *Missed Appointments Policy – Twenty-five dollars ($25) will be charged to your account for an acute or follow up appointment that is missed. A fifty dollar ($50) charge will be assessed to your account for a New Patient or Physical appointment that is missed.. This charge will have to be paid before being scheduled again.*
            - *Patients showing up ten (10) minutes or later after their scheduled appointment will be considered as a "no show" and will need to be rescheduled and charged a $25.00 fee unless there is a attestable explanation for being late.*

Patient Drug Refill Policy

- To make it easier for patients, most Pharmacies will take the patient refill request and will fax or send it electronically to Wagner & Prigg Family Medicine Practice. The request will then be given to the provider for approval and will be electronically sent or faxed back to the Pharmacy to fill.
- ***For all other requests please call 48 hours before your prescription runs out and allow 24 hours for it to be filled. Unless it is a medication that your insurance company requires a Prior Authorization, in this case it may take up to a week.***

- You may also use the secure on-line patient portal to ask for a prescription refill, ask a medical question, check your lab results or request an appointment. Please ask one of our staff how to sign up for our Patient Portal.
- ***Controlled substances medicine (Percocet, Adderall, etc.) Most prescriptions are now sent electronically to the pharmacy and may be picked up directly at your pharmacy.*** **If there are controlled medications that cannot be sent electronically, you will need to pick up the prescription from Wagner & Prigg Family Medicine.**

  - When calling to ask or tell the provider something, please provide the Wagner & Prigg Family Medicine Staff Person your name, the problem, a phone that you may be reached on. If it is a refill request the name of your medication, the amount and instructions given for taking the medication.

  - Our Providers usually call back during the early afternoon or late afternoon.

  - If at some time you will need to be admitted to a hospital, you will be directed to go to the hospital of your choice and will be admitted by the Hospitalist or an attending, on call or employed by that hospital.

  - **If you are having an operation performed by a specialist, or have been admitted to a rehab facility please call or have someone call to notify us. If you are discharged from the hospital and we are notified, we will call you to set up a follow up appointment, called a "Transition of Care". However, sometimes we are notified that you are or have been discharged and sometimes we are not notified, so please call our office to inform us of your discharge and set up an appointment.**

Forms: If you have a form to be filled out and you are not at your appointment the charge to fill out the form is $5 - $10 per sheet, based on the difficulty of the form being filled out, which needs to be paid before you receive the completed form.

Insurance Referral Policy: If your insurance requires you to obtain a referral before seeing a specialist or getting a diagnostic test. It is your responsibility to contact our office at least five days (5) before your appointment so we will have time to do the necessary paperwork,

IT HAS BECOME INCREASINGLY MORE IMPORTANT FOR YOU TO GET YOUR REFERRAL BEFORE YOU GO TO A SPECIALIST OFFICE. IF YOU DO NOT GET THE REFERRAL, YOUR VISIT WILL NOT BE PAID FOR AND YOU WILL BE CHARGED BY THE SPECIALIST. ALSO IT HAS BECOME INCREASINGLY DIFFICULT TO GET A BACKDATED REFERRAL. SO PLEASE REMEMBER.

WHEN YOU GET THE APPOINTMENT, FIND OUT IF YOU NEED A REFERRAL

PATIENT INFORMATION SHEET

FIRST NAME: MIDDLE: LAST:		BIRTH DATE:
ADDRESS:	SEX: Male or Female	SS #
	MARITAL: S M D W	Home Phone:
CITY/TOWN: ZIP CODE:	Cell Phone:	Work Phone:
Emergency Contact Person:	Relationship:	Race: African Amer., Asian, Hispanic, White, Native Amer.

BILL TO INFORMATION IF OTHER THAN THE PATIENT	
Name:	Relationship:
Address:	Home Phone:
	Cell Phone:

Primary Insurance Information	Secondary Insurance Information
Name of Insurance:	Name of Insurance:
Policy Number:	Policy Number:
Group Number:	Group Number:
Policyholder Name: D.O.B	Policyholder Name: D.O.B

PATIENT PAYMENT AUTHORIZATION

I authorize payment directly to Wagner & Prigg Family Medicine Practice. I permit a copy of this authorization to be used in place of the original. I agree that this authorization shall be deemed valid until revoked in writing or replaced by another authorization at a later date. I authorize my doctor to act as my agent in helping obtain payment from my insurance companies. I authorize release of my information to my insurance companies to obtain payment. I understand that I am responsible for my bill. I agree to pay for any collection charges that may be incurred should this account be placed with a collection.

HIPAA'S PRIVACY CONSENT FOR INFORMATION TO BE RELEASED TO OTHER INDIVIDUALS

The Health Insurance Portability Act of 1996 requires patients to give written permission to healthcare providers before any of their personal information can be given out. This includes phone calls, appointments, presence in the office, prescription request, and specific medical information. It is YOUR responsibility to update the information contained below.

1. ***I permit the following individuals to obtain information on my behalf regarding appointments, my presence in the office and/or prescription request***. ____

2. ***I permit the following individuals to discuss my medical conditions Providers and/or staff of Wagner & Prigg Family Medicine.***
____

3. Vaccination information of patients, such as Flu shots, pneumovax, tetanus, etc. is sent to the State of Delaware so physicians can better receive information on whether a patient has been vaccinated. **If YOU DO NOT** want this information sent to the State Registry please check here and sign. ☐ I ______________________________ ***do not*** want my vaccine information sent to the State of Delaware registry.

PATIENT/PARENT OR GUARDIAN SIGNATURE: ________________________________DATE: __________

If a Legal representative signs, what is the relationship to the patient. ____________________________.

____

WAGNER & PRIGG FAMILY MEDICINE

HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and 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 care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications. This notice informs me that the Notice of Privacy Practice, containing a more complete description of the uses and disclosures of my health information, is available to me in print form at the Check In and Check Out offices at both the front and back waiting areas.

I have been given a chance to review such Notice of Privacy Practices prior to signing this consent and have reviewed or have declined to review the Notice of Privacy Practices. If reviewed, I acknowledge I have studied the Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the following address to obtain a current copy of the Notices of Privacy Practices. Wagner & Prigg Family Medicine, 16529 Coastal Highway, Lewes, DE 19958, (302) 684-2000

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is a bound to abide by such restrictions.

I understand that I am able to revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

PLEASE CIRCLE ONE AND SIGN BELOW.

I have reviewed   I have declined   to review this document:

_________________________________   ____________________________

Print Patient's Name   DOB: (mm/dd/yy)

_________________________________   ____________________________

Signed (Patient or Legal Representative for Patient)   Date:

If Legal Representative's signs what is the Relationship to patient. ____

Wagner & Prigg Family Medicine
Opiate/Controlled Substance Medication Policy

Patient Name ____________________________________

Diagnosis ____________________________________

Telephone / Contact Number ________________________

This form is an agreement between the patient noted above and the Providers of Wagner & Prigg Family Medicine **if** given a controlled medication for the relief of pain. I agree to abide by the following guidelines for managing my prescriptions for pain/controlled substance medication:

I will only request and receive opiate (narcotic) pain medications and other controlled substances that may help in the management of my condition for Wagner, MD & Prigg, PA-C, PhD Family Medicine. I agree to inform any other physicians participating in my care of this agreement. If another provider wishes to suggest changes in these prescription medications, they should contact Wagner, MD & Prigg, PA-C PhD Family Medicine during regular business hours, but no changes will be made without such contact.

I agree that refills of my prescriptions for pain/controlled substance medications will be made only at the time of an office visit or during regular office hours. I understand, if calling in for a refill, I must call in at least 48 hours before the medication runs out. No refills will be available during evening or on weekends.

I will not partake of any illegal medications, or substances while being prescribed controlled substances by one of the Providers at Wagner, MD & Prigg, PA-C, PhD Family Medicine.

I understand that if my medicines are lost or stolen, they will not be refilled prior to the next refill date. If I use up my supply of medications before the date of the next refill, I understand that my doctor will not provide extra medications. If I find the current dose of pain medication is no longer adequate; I will discuss this with my provider at a scheduled office visit.

I agree not to sell or share any opiate or other controlled substance medications.

I agree to use the following pharmacy: ____,

Located at ____Telephone Number: ________________,

For the filling of all of my pain/controlled substance medication prescriptions.

If I violate the terms of this policy, I understand that Wagner MD., & Prigg, PA-C, PhD will no longer prescribe opiate or other controlled substance medications for me. Violations of this policy may also be grounds for dismissal from Wagner & Prigg.

Signature ____ Date: ____________________________

PRINT NAME: ____DOB:_______________

HEALTH SCREENING HISTORY

Test/Screening/Services	Description	Date Received	Next Test Due
Abdominal Aortic Aneurysm Screen	A one-time screening, within the first 12 months that you have Medicare Part B		
Bone Mass Measurement	Every 2 years, as screening for risk of fracture (more often if medically necessary)		
Cardiovascular screening	Once every 5 years, a blood test that checks your cholesterol		
Fecal Occult Blood Test	Once every 12 months, if 60 or older (if you are refusing recommended colonoscopy)		
Colonoscopy	Once every 10 years; high risk every 24 months up to age 75		
Diabetes Screening	Up to two test per year, if you have risk factors		
Flu Shot	Once per flu season		
Hepatitis B vaccine	Covered for high to medium risk patients		
Mammogram	Once a year for woman 40 or older until age of 75		
Pap test and pelvic exam (includes breast exam)	Once every 2 years or once a year for woman at high risk (may stop if > 65 and previous Pap's normal or if hysterectomy without caner		
Pneumococcal Vaccine (Pneumonia Vaccine)	Once every 5 years after age 50, until age 65		
Prostate Cancer Screen	Once every 12 months for digital rectal exam & PSA blood test for men over 50 (if fam hx prostate CA or African American, than >45		
Glaucoma Screening Exam	Once a year, if you are at increased risk for glaucoma		
Annual Wellness Exam	Once a year		
Tetanus (Td)	Every 10 years		

PERSONAL RISK FACTORS (Circle any that applies)

Smoking	Lack Of Exercise	Other:
Alcohol/Drug Use	Stress	
Obesity	Proper Nutrition	

WAGNER & PRIGG FAMILY MEDICINE
NEW PATIENT HEALTH HISTORY FORM

INSTRUCTIONS: Please fill out to the best of your ability, the Nurse and Provider will help and ask you questions on areas of concern on the form. Thank you.

Date: ____________ Name: ____ Date of Birth:_________________

Married ☐ Single ☐ Divorced ☐ Widowed ☐ Occupation:

____

Disabled : Yes ☐ No ☐ If yes type of disability:

____

Tobacco use: Do you smoke now? Yes ☐ No ☐ Have you smoked more than 100 cigarettes in your life time?

Yes ☐ No ☐

Alcohol/Rec. Drug use: Yes ☐ No ☐ Never ☐ No. of drinks/wk.? Caffeine (coffee, tea, colas) per day?

How did you find out about us? Newspaper - Internet - Local Book - Yellowpages - Verizon Yellowpages – Friends/Family

Main reason for your visit today:

____

Other concerns/questions:

____

PAST ILLNESSES/FAMILY HISORY: Have you or any family member have or ever had any of the following:

YOU / YOUR FAMILY	RELATIONSHIP	YOU / YOUR FAMILY	RELATIONSHIP	YOU / YOUR FAMILY	RELATIONSHIP
☐ ☐ ALCOHOLISM	_____	☐ ☐ HIGH BLOOD PRESSURE	_____	☐ ☐ STROKE	_____
☐ ☐ ANEMIA	_____	☐ ☐ KIDNEY DISEASE	_____	☐ ☐ SUICIDE ATTEMPT	_____
☐ ☐ ASTHMA	_____	☐ ☐ LIVER DISEASE	_____	☐ ☐ THYROID DESEASE	_____
☐ ☐ CANCER/TUMOR	_____	☐ ☐ HEPATITIS	_____	☐ ☐ TUBERCULOSIS TB	_____
☐ ☐ DIABETES	_____	☐ ☐ LUNG DISEASE	_____	☐ ☐ ULCER IN GI TRACK	_____
☐ ☐ DRUG ABUSE	_____	☐ ☐ MENTAL ILLNESS	_____	☐ ☐ VENEREAL DISEASE	_____
☐ ☐ DEPRESSION	_____	☐ ☐ OSTEOARTHRITIS	_____	☐ ☐ HIGH CHOLESTEROL	_____
☐ ☐ EPILEPSY/SEIZURES	_____	☐ ☐ OSTEOPOROSIS	_____	☐ ☐ HIV/IMMUNE DX	_____
☐ ☐ GLAUCOMA	_____	☐ ☐ PHLEBITIS	_____	☐ ☐ HEART DISEASE	_____
☐ ☐ SLEEP APNEA	_____	☐ ☐ BIPOLAR	_____	☐ ☐ RHEUMATIC ARTHRITIS	_____
☐ ☐ SICKEL CELL	_____	☐ ☐ GOUT	_____	☐ ☐ DEMENTIA	_____
☐ ☐ G6PD	_____	☐ ☐ THALESSEMIA	_____	☐ ☐ BLEEDING DISORDERS	_____

OTHER _________________________

RELATION SHIP KEY: M = Mother F= Father B = Brother S = Sister

MEDICATION LIST		
ASPIRIN YES ☐ NO ☐	**VITAMINS YES ☐ NO ☐**	**CONTRACEPTION YES ☐ NO ☐**
MEDICATION	**DOSE (mg/pill)**	**Times per day**

List on back of page if more space required.

Allergies or intolerance to medications **(include type of reaction)** **NONE** ☐

____ ____

____ ____

____ ____

PAST **SURGICAL HISTORY** (Please include dates)

Surgery	Date	Surgery	Date	Other Surgery List	Date
Prostate		Knee Replacement			
Heart Surgery		Hip			
Cataract		Gall Bladder			
Appendix		Hysterectomy			
Tonsils					

Other: ____

____

REVIEW OF SYMPTOMS: Please mark the box and/or circle any **persistent** symptoms you have had in the past few months

GENERAL:	YES	NO
Weight Loss	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Night Sweats	☐	☐
EYES:		
Glasses/contacts	☐	☐
Eye pain	☐	☐
Double vision	☐	☐

NOSE/THROAT:		
Difficulty hearing	☐	☐
Ringing in ears	☐	☐
Vertigo	☐	☐
Sinus trouble	☐	☐
Nasal Stuffiness	☐	☐
Frequent sore throat	☐	☐
Nose Bleeds	☐	☐
Difficulty Swallowing	☐	☐

RESPIRATORY:	YES	NO
Cough	☐	☐
Coughing Blood	☐	☐
Wheezing	☐	☐
Chills	☐	☐

CARDIOVASCULAR:		
Murmur	☐	☐
Chest Pain	☐	☐
Palpitations	☐	☐
Shortness of breath	☐	☐
Difficulty lying flat	☐	☐
Swelling ankles	☐	☐

GASTROINTESTINAL:	YES	NO
Heartburn/reflux	☐	☐
Nausea/vomiting	☐	☐
Constipation	☐	☐
Change in bowel habits	☐	☐
Diarrhea	☐	☐
Jaundice	☐	☐
Abdominal Pain	☐	☐
Black or Blood BM	☐	☐
Discolored Stool	☐	☐

GENITOURINARY:		
Burning/frequency	☐	☐
Blood in the urine	☐	☐
Erectile Dysfunction	☐	☐
Abnormal discharge	☐	☐
Bladder leakage	☐	☐
Nighttime Incontinence	☐	☐
Kidney Stone	☐	☐

NEUROLOGICAL	YES	NO
Memory Loss	☐	☐
Loss of strength	☐	☐
Numbness	☐	☐
Headaches	☐	☐
Tremors	☐	☐
Dizziness	☐	☐
Fainting spells	☐	☐

MUSCULOSKELETAL	YES	NO
Joint pain/swelling	☐	☐
Stiffness	☐	☐
Muscle pain	☐	☐
Back pain	☐	☐
Morning Stiffness	☐	☐

SKIN:		
Rashes/sores	☐	☐
Lesions	☐	☐
Itching/burning	☐	☐

HEMATOLOGY/ LYMPH NODES :	YES	NO
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Enlarged Glands	☐	☐

ALLERGIC/ IMMUNOLOGIC	YES	NO
Hives/eczema	☐	☐
Hay fever	☐	☐
PHYCHIATRIC		
Anxiety/depression	☐	☐
Mood swings	☐	☐
Difficulty sleeping	☐	☐
Suicidal Thoughts	☐	☐

ENDOCRINE:		
Loss of hair	☐	☐
Heat/cold intolerance	☐	☐
O.S.A	☐	☐

FEMALES ONLY:	Yes	No
Bloating/cramps/ Irritability	☐	☐
Problems with menses	☐	☐
Irregular Periods	☐	☐
Hot flashes/nightsweats	☐	☐

Date of last PAP ___________

Number of pregnancies _______

Last Menses ______________

WAGNER, MD & PRIGG, PA-C, PhD – FAMILY MEDICINE

Jennifer Hurd, M.D. **Robert Barwick, PA-C**
Brian Prigg, PA-C PhD **Susan Parks, FNP-BC**
Catherine DeLuca, MD **Jennifer Shade, NP-C**

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient: ___________________________________ DOB: _______________ SS# ___________________

Physician / Person Releasing Records:
Name: _____________________________
Address: ____________________________
City, State, Zip: _______________________
Phone/Fax: _________________________

Physician / Person to Receive Records:
Name: ______________________________
Address: ___________________________
City, State, Zip: ______________________
Phone/Fax: __________________________

Medical Information to be sent:
_____ENTIRE medical records, INCLUDING information related to the treatment for substance abuse or dependency, psychiatric or mental health treatment, information related to testing or treatment of sexually transmitted diseases, hepatitis and HIV/AIDS.

_____ENTIRE medical records, EXCLUDING information related to the treatment for substance abuse or dependency, psychiatric or mental health treatment, information related to testing or treatment of sexually transmitted diseases, hepatitis and HIV/AIDS.

_____RECORD OF CARE ______ TO ______, INCLUDING information related to the treatment for substance abuse or dependency, psychiatric or mental health treatment, information related to testing or treatment of sexually transmitted diseases, hepatitis and HIV/AIDS.

_____RECORD OF CARE ______ TO ______, EXCLUDING information related to the treatment for substance abuse or dependency, psychiatric or mental health treatment, information related to testing or treatment of sexually transmitted diseases, hepatitis and HIV/AIDS.

This release applies to all information in my medical record protected under the regulation in 42 Code of Federal Regulations, Part 2.

I authorize medical information to be released as indicated above. I understand this release is effective until I revoke my consent by providing written consent to the above named party, I understand there may be a charge involved when multiple copies are requested.

Patient or Legal Guardian _________________________________ Date: _______________________

Witness ____ Date: _______________________

WAGNER & PRIGG FAMILY MEDICINE

I, ___________________________________ have read the previous policies and understand this is a patient contract between myself and Wagner & Prigg Family Medicine Practice. Wagner & Prigg Family Medicine reserves the rights to change any part of these policies at any time. Please request a new policy at your first appointment in each year.

This signed statement will be scanned into your digital/electronic chart.

Signature ____ Date: ________________

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YOUR APPOINTMENT

Preparing for your appointment

1. Make a list of your health questions. Ask a friend or relative for help if you need it. Put the questions that are most important to you at the top of the list. Even if you cannot get all of your answers on the first visit, having a list will help you keep track of the answers.
2. If you have moved or moving from another area, talk with your previous provider about what health issue to work on first for you.
3. Make a list of other health care providers you have visited. Write down their names, addresses, phone numbers and the reasons you visited them.
4. If this is your first visit to this provider, take all of your medicines, in their original containers, to your appointment. Be sure to include prescription, over-the-counter, natural and herbal medicines and vitamins. Following appointments you may bring an updated list of any new changes in your medication to give to the nurse or Provider to review.

PAYING FOR YOUR VISIT

INSURANCE

1. Wagner & Prigg Family Medicine is contracted with Medicare, Delaware Medicaid, most Blue Cross, most United Health Care, Aetna, and other insurances. However, if you have a commercial insurance, Blue Cross, Aetna, etc, make sure Wagner & Prigg Family Medicine is contracted with them. We are contracted with most medical insurances, if you need to select a Primary Care Provider, please select which ever physician you are seeing, some insurance only need the group practice you are going to.
2. Make sure you have your insurance cards; ***we will not be able to see you unless you have your insurance card, which will be verified, and another form of identification***.
3. COPAYMENTS (COPAY) If you have a commercial insurance you may have an agreement with your insurance company and yourself (a contract) that you will pay copay for different physician visits. These generally will be listed on your insurance card and will say for example: Primary Care $10.00 Specialist $20.00. ***You must pay this copay before the office visit so please have a method to pay or you may not be seen***. We accept cash, checks and major credit cards.
4. Self Payments; We accept most major credit cards, checks, cash or money orders, office visits must be paid at the time of service unless prior arrangements have been made.
5. Patient balances: If you have a balance that you owe on your account this must be paid before you see your provider. If your balances or more than three months old we will not schedule an appointment for you until the balance is paid and you will be charged$10 each month late after the three months.

Checking In for your appointment:

1. At your first visit, if you have not already done so, you will need to fill out paper work. Yes, we know there is a lot to fill out however we will be able to pay attention to your medical condition more readily if we know a little about you and your medical history. Also the federal government requires us to notify you of your rights and privacy concerns. We try to send the paper work in the mail and you may also down load it to your computer and print it off to fill out before your appointment. Our Web site is www.lewesdoctor.com please visit it and access information about our Providers and medical information.
2. You will be asked for your insurance card(s), a picture Identification, and if you have a copay or a balance from a previous visit you will need to pay it at this time.

During your appointment:

1. Please feel relaxed, the nurse and the provider will want to know about your medical history and will ask you many questions take your time and be as accurate as you can be.
2. Listen to your Provider and if you do not understand or you are confused about something do not be afraid to ask your provider or the nurse.
3. Use your own words to repeat back the things you've discussed with your provider. This way both you and your provider will know the information given to you is clear
4. Before you leave the office, be sure you know the things you need to work on before your next appointment; and be sure to schedule your next appointment at this time.

At Check out:

1. If you are to referred to another specialist make sure you have his name and address, we may make the appointment for you.
2. Your Provider may want you to get labs; if your follow up appointment is within a month we will make the appointment at check out and give you a lab request form. If you go to LabCorp, we will soon have the ability to send your lab request electronically and any LabCorp will be able to access your request. If your follow up appointment is to be scheduled later than a month, can make the appointment at that time, or we will send you a reminder letter or phone call to make your appointment, we find if we remind our patients around the time they are due for another appointment they do not forget as much.
3. This is the time to ask if you still have questions or you are confused about what we would like you to do, please don’t hesitate to ask.

OTHER INFORMATION YOU SHOULD KNOW

Our Practice philosophy is to see our patients when they are sick, if you call in the morning we will try to get you in with either your provider or one of the other excellent Providers in our office. If calling in the afternoon, if it is early enough, we will try to get you in, however if we are unable we will see you the next day. Please remember we are a busy practice, Dr. Wagner has chosen all the excellent providers who work at this practice and he feels they all are competent and caring, please do not hesitate to see one of them if you are sick and your regular provider is not available.

WAGNER & PRIGG FAMILY MEDICINE

We have our own secure patient portal please ask any of our staff at your visit about the portal. You can request appointments, review your lab information, request refills, ask medical questions of your provider and many more things.

AFTER HOURS:

We have one of our own Providers on-call after hours and on weekends, if you become sick please call our office phone 302-684-2000 and you will be directed to how to contact one of our own on call Providers.