To our new patient(s):

We would like to take this time to welcome you to our practice. Our providers have over 80 years of medical experience in Family or Primary Care and will create a health care plan based on their shared expertise.

Please take time to read Pointe Primary Care's Patient Policies and complete the following forms to provide us with as much of your past medical history as possible. The more we know about your medical history, 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.

Remember to bring:

- Your insurance card(s).
- We will need your driver's license or a picture ID.
- Bring a list of medications that you take or bring the medications with you.
- 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 your previous physician.

Thank you for selecting our practice.

Jennifer Hurd, MD
Brian Prigg, PA-C, PhD
Susan Parks, NP
Jennifer Shade, NP
Jennifer Willey, NP

Pointe Primary Care

Pointe Primary Care

PATIENT POLICY LIST

PLEASE KEEP THESE NEXT THREE PAGES FOR YOUR USE

Scheduling Hours Monday - Friday
8:00 AM – 12 PM
1:00 PM – 4:30 PM
*Evenings Hours Monday and Tuesday until 7:30 PM

If you are sick or injured, we will offer you an appointment the same day or within 24 hours.

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

  - All co-pays are due when the patient checks in for his/her appointment.
  - We ask that Medicare coinsurance 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.
  - For self-pay patients: your balance is due at the time of visit; if paid at the time of check-out, there is a 20% discount.
  - Patients who owe a balance on their account must pay at the time of check-in before seeing the Provider.
  - *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; a payment must be made prior to scheduling an appointment.*

- **Appointments**
  - **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 PM, we will attempt to see you that afternoon. If we are not able to accommodate you, we will offer an appointment for the next morning.

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

  - **Follow-up appointments** – Generally scheduled after you have had any diagnostic test.

  - **Missed Appointments – We would like all our patients to understand, we set aside specific time slots for their appointments. It's imperative that patients keep their scheduled appointments as another sick patient could have been scheduled.**

    - *Missed Appointments Policy – A fifty-dollar charge ($50) will be added to your account for an acute or follow-up appointment that was missed. Missed is defined as a "no-show" or a cancellation within 24-hours of your appointment.*

- ***Patient Drug Refill Policy***

  - To make refills easier for patients, most pharmacies will take the patient refill request and send it to the office for a provider to fill
  - ***For all other requests, please call 48 hours before your prescription runs out and allow 24 hours for the prescription to be filled.***
  - You may use the 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.

- **For Your Information**

  - When calling to speak with the provider, please provide the Pointe Primary Care patient representative with your name, the problem, and a phone number. If you are requesting a refill please leave the name of your medication, the amount, and instructions given for taking the medication.

  - Your message will be returned within two business days.

  - **If you are discharged from the hospital, we may call you to set up a follow up appointment called a "Transition of Care." Sometimes we are notified that you are being 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, there is a charge of $5 per sheet due at the time of pick-up.

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 to allow time to process the request.

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

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

What is the difference between a physical and an office visit?

Pointe Primary Care defines a "physical" appointment as a preventative health maintenance visit to review your general health and discuss screening exams and tests. Your provider will review health maintenance issues and screening tests and perform a targeted physical examination in order to make general and specific recommendations concerning your health. This may include general recommendations regarding diet and exercise, age appropriate immunizations, and cancer screening tests such as a colonoscopy, mammogram, Pap test, or prostate exam.

We define an "office visit" as an appointment to discuss new or existing medical conditions or problems. The questions and exam will focus on the conditions or problems discussed and recommendations for treatment or further evaluation will be given. The visit may include prescribing and reviewing medications, ordering or reviewing labs or X-rays, and performing in office procedures like an EKG. The visit may also include discussions regarding other treatment options and referrals to specialists.

Occasionally, you may be seen for both a physical and an office visit on the same day. This means that you satisfy the requirements for both types of visits during one appointment. For example, if you scheduled a physical but you and the provider discuss new or existing problems during that appointment in addition to the preventative health maintenance topics, then your insurance would be billed for both a physical and an office visit which may result in patient responsibility for a co-pay or co-insurance.

We hope this information is helpful. We want to provide you with the highest quality medical care possible. If you need further information regarding this, please contact our office.

Cancellation Policy

Dear Pointe Primary Care Patients:

Our goal is to provide exceptional medical care to our patients. We maintain an appointment system and standards in order to do this effectively.

"No-shows" and late cancellations negatively impact other patients who also need access to medical care. To deter these instances from happening we have decided to institute a Cancellation Policy. Please see our policy listed below:

- **We request that you give our office at least 24-hour notice if you need to cancel or reschedule your appointment. You may call our office at 302-684-2000 and select Option 1 to cancel or reschedule an appointment.**

- **If you miss an appointment or do not contact us with at least 24-hour notice you will be charged a $50.00 fee. This applies to late cancellations and "no-shows".**

This fee is not covered by your insurance and will be billed to you directly. Payment will be expected in a timely fashion and must be paid prior to your next appointment.

Thank you for your patronage and continuing to trust Point Primary Care with your medical care.

_____ _____

PATIENT OR PARENT/GUARDIAN SIGNATURE **DATE**

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:		
Emergency Contact Person:		Phone:	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 Pointe Primary Care. 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 in collections.

PATIENT/PARENT OR GUARDIAN SIGNATURE: _____DATE:_____

Pointe Primary Care

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 I may contact this organization at any time at the following address to obtain a current copy of the Notices of Privacy Practices. Pointe Primary Care, 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 can revoke this consent in writing at any time, except to the extent that the organization has acted relying on this consent.

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

The Health Insurance Portability and Accountability 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 with Pointe Primary Care Physician and/or staff.

3. Vaccination information of patients such as flu shots, pneumovax, tetanus, etc. is sent to the State of Delaware so physicians can obtain vaccination information. 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: _____

Pointe Primary Care
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 Pointe Primary Care 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 from Pointe Primary Care. 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 Pointe Primary Care 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 Pointe Primary Care.

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 my pain/controlled substance medication prescriptions.

If I violate the terms of this policy, I understand that Pointe Primary Care will no longer prescribe opiate or other controlled substance medications for me. Violations of this policy may also be grounds for dismissal from Pointe Primary Care.

Patient Signature: _____ Date: _____

PRINT NAME: _____DOB:_____

Provider Signature: _____ Date: _____

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 (Pneumovax)	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, >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 apply*)

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

POINTE PRIMARY CARE

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 lifetime? 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 - Yellow pages - 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. Please indicate which family member on the line provided:

YOU / YOUR FAMILY	YOU / YOUR FAMILY	YOU / YOUR FAMILY
□ □ 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 _____

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

MEDICATION LIST

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:	YES	NO
Glasses/contacts	☐	☐
Eye pain	☐	☐
Double vision	☐	☐
Cataracts	☐	☐
Flashes	☐	☐
Lazy Eye	☐	☐
Blurry Vision	☐	☐

NOSE/THROAT:	YES	NO
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:	YES	NO
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:	YES	NO
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:	YES	NO
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	☐	☐

PSYCHIATRIC	YES	NO
Anxiety/depression	☐	☐
Mood swings	☐	☐
Difficulty sleeping	☐	☐
Suicidal Thoughts	☐	☐

ENDOCRINE:	YES	NO
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 _____

Jennifer Hurd, MD
Brian Prigg, PA-C, PhD
Jennifer Shade, NP
Jennifer Willey, NP
Susan Parks, NP

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: _____

Pointe Primary Care

I, _____ have read the previous policies and understand this is a patient contract between me and my primary care provider. Pointe Primary Care reserves the right to change any part of these policies at any time. This signed statement will be scanned into your digital/electronic chart.

Signature _____ Date: _____

Pointe Primary Care

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 how to contact our own on call Provider.

POINTE PRIMARY CARE

Providing Quality Health Care

The Patient Portal connects patients with their primary care provider through a secure website.

We have now launched Pointe Primary Care's Patient Portal for our patients.

Our patients may go online and:

- ✓ **Edit/change their address, phone number, insurance information, etc.**
- ✓ **Ask for refills of medication.**
- ✓ **Ask a medical question.**
- ✓ **Request an appointment.**
- ✓ **Download and print educational materials about medical conditions.**
- ✓ **View their recent lab reports.**

The Patient Portal is an easy method to work as a team and improve your health.

INFORMATION ABOUT OUR PATIENT PORTAL

If you would like to access our patient portal, please complete the following questionnaire.

Do you own a computer?	**YES**	**NO**
Do you have an email address?	**YES**	**NO**
Would you like to be able to ask questions about you or a family member online?	**YES**	**NO**
Would you like to make appointments with our practice online?	**YES**	**NO**
Would you like to be able to ask a question related to you or your family members health online?	**YES**	**NO**
Would you like to download information online about a medical problem?	**YES**	**NO**
Would you like to pay your bill online?	**YES**	**NO**

If you answered yes to most or all these questions, please request an invitation be sent to your email address.

My name is: _____

My date of birth is: _____

My email address is: _____

YES, I would like to sign up for Pointe Primary Care's Patient Portal, and I give permission to send medical information to this secure website about my medical health.

_____ _____
Signature Date

NO, I am not interested in signing up to for the Patient Portal.

_____ _____
Signature Date