BRANDYWINE
MEDICAL ASSOCIATES

☐ **Wilmington (Station)**
1815 West 13th Street
The Station, Suite 1
Wilmington, DE 19806
302.652.4705

☐ **Pike Creek**
2601 Annand Drive
Heritage Plaza, Suite 23
Wilmington, DE 19808
302.994.4406

New Patient Registration Form				
Today's Date:	Last Name:	First Name:		MI:
Street Address:		City:	State:	Zip Code:
Marital Status:	Social Security #:	Date of Birth:	Age:	Sex:
Home Phone:	Cell Phone:	Work Phone:	Email address:	
Employer		Occupation		
Emergency Contact:		Relationship to Patient:		
Phone: Home #		Work #	Cell #	
Primary Care Physician:			Tell #	
Responsible Person:		DOB:	Relationship:	

Insurance Authorization & Assignment:	
Authorization to File/Release Information: I hereby authorize BRANDYWINE MEDICAL ASSOCIATES to release any medical information to my insurance company or third part payers for completion of insurance claims and determination of benefits. **Medicare Patient's Signature:** I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program or its intermediates or carriers or to the professional Standards Review Organization.	
Assignment of Benefits: I assign payment directly to BRANDYWINE MEDICAL ASSOCIATES for all medical services provided to me and/or my dependents by BRANDYWINE MEDICAL ASSOCIATES.	
HIPPA PRIVACY ACKNOWLEDGEMENT: I hereby acknowledge that I have received and reviewed the NOTICE OF THE PRIVACY PRACTICES from BRANDYWINE MEDICAL ASSOCIATES.	
Patient or Guardian Signature:	**Date:**

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

BRANDYWINE MEDICAL ASSOCIATES

With my consent, BRANDYWINE MEDICAL ASSOCIATES, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Please refer to BRANDYWINE MEDICAL ASSOCIATES's Notice of Privacy Practices for a more complete description of such uses and disclosures.)

With my consent, BRANDYWINE MEDICAL ASSOCIATES may disclose my PHI to the following individuals (family, relatives or friends) who may assist in my care: _____

(Please indicate name of individuals to whom BRANDYWINE MEDICAL ASSOCIATES may release PHI)

I have the right to review the Notice of Privacy Practices prior to signing this consent. BRANDYWINE MEDICAL ASSOCIATES reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to BRANDYWINE MEDICAL ASSOCIATES's Privacy Officer at 161 Becks Woods Drive, Bear, DE 19701.

CONSENT FOR CALLS TO HOME

With my consent, BRANDYWINE MEDICAL ASSOCIATES may call my home or other designated location and leave message on my voice mail or in person in reference to any item that may assist BRANDYWINE MEDICAL ASSOCIATES in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

CONSENT FOR MAIL

With my consent, BRANDYWINE MEDICAL ASSOCIATES may mail to my home or other designated location any item that may assist

BRANDYWINE MEDICAL ASSOCIATES in carrying out TPO, such as appointment reminder cards and patient statement as long as they are marked PERSONAL AND CONFIDENTIAL.

CONSENT FOR E-MAIL ADVICES

With my consent, BRANDYWINE MEDICAL ASSOCIATES may e-mail to my designated e-mail address any message in reference to any item that may assist

BRANDYWINE MEDICAL ASSOCIATES in carrying out TPO, 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 that BRANDYWINE MEDICAL ASSOCIATES restrict how it uses or discloses my PHI to carry out the TPO, However,

BRANDYWINE MEDICAL ASSOCIATES 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 BRANDYWINE MEDICAL ASSOCIATES's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that BRANDYWINE MEDICAL ASSOCIATES has already made disclosure in reliance upon my prior consent. If I do not sign this consent, BRANDYWINE MEDICAL ASSOCIATES may decline to provide treatment to me.

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Patient's Name — Date

_____

Print Name of Patient or Legal Guardian

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

FINANCIAL POLICY

BRANDYWINE MEDICAL ASSOCIATES

Thank you for choosing us as your Primary Care Provider. We are committed to providing you with a consistently high standard of care and pleased to discuss our services at any time. Your clear understanding of our Financial Policy is an important part of our professional relationship. We request that you take time to review it and sign our acknowledgement form prior to receiving treatment from us. If you have any questions about our fees, financial policy or your responsibility, please ask to speak with our Practice Manager.

Our practice is committed to providing the highest standard of care for our patients and our fees are considered usually the customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of "usual and customary rates."

Full payment is due and expected at the time of service. You may make your payment by cash, check, or credit card. It is our policy to charge a fee of $35 for any returned check.

Your insurance coverage is a contract between you and your insurance company. We will file an insurance claim as a courtesy to our patients; however, this does not release you of your financial responsibility. If your insurance company has not paid your account within 60 days from the time of service, the outstanding balance automatically becomes your responsibility. We will not be involved in the disputes between you and your insurance company regarding deductibles, co-pays, covered charges, etc. other than to supply factual information as necessary. Please be advised that some and perhaps, all of the services provided to you may be considered a non-covered service or medically unnecessary by your insurance. In this case, you will be financially responsible for the timely payment of your account. For those who request it, we provide an estimate of the cost of the service to be performed, if such information is available to us.

As a patient, it is your responsibility to advise us if you have a change in your demographic and insurance information. To protect our patients against identity theft, we require you to present a valid health insurance card and a photo identification card, preferably a state issued one at each time of visit. We will also need a proof that would reflect any demographic or insurance information change. All copays and balances are due at time of visit and will be collected before you see the physician. We reserve the right to take lawful actions including terminating our physician-patient relationship for nonpayment.

Any minor patient must be accompanied by an adult representative who has assumed financial responsibility for the minor patient.

You must notify us at least 24 hours in advance if you need to cancel your appointment. We charge a "no show fee" of $30.00 for established patients, $60 for physical exams, and $60.00 for new patients if we are not notified at least 24 hours in advance.

We are mandated by federal regulations to obtain a written authorization for release of medical information. We follow the guidelines set by the Delaware Secretary of Department of Health for charging for reproduction of medical records. Our fee schedules are as follows:

Amount charged per page for pages 1-10.....	$2.00
Amount charged per page for pages 11-10	$1.00
Amount charged per page for pages 21-60	$ .90
Amount charged per page for pages 61 and above	$ .50

In addition to the amounts listed above, charges will also be assessed for the actual cost of postage, shipping and delivery of the requested records. Payments of all costs are required in advance of release of the records except for records requested to make or complete an application of disability benefits program. We understand that due to a medical condition, you may file an insurance or disability form. Please be aware that we charge $30-$50 per form.

Thanks for taking time to review our financial policy. Please let us know if you have any questions and concerns.

I hereby acknowledge and agree to the financial policy mentioned above:

Patient Signature: _____ Date: _____

Patient Medical History Form

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

To help the doctor serve you better, please complete the information below. Thank you!

Allergies: □ No known Allergies (If yes, please list all Drug, Food, and Environmental Allergies below:)

_____

_____

Medications: Preferred Pharmacy: _____ Location: _____

Please list all current Over the Counter and Prescribed Medications with their corresponding dosages: (if known)

NAME OF MEDICATION	STRENGTH	HOW OFTEN?

Personal Medical History: Did you in the **Past**, or do you **Currently** have problems with any of the following? (Please check all that apply to YOU) and tell us, to the best of your knowledge:

CONDITION	PAST	CURRENT	DATE/ AGE ONSET:	DATE/AGE RESOLVED:
ABDOMINAL PAIN- CHRONIC				
AGITATION				
ALCOHOL ABUSE/ ADDICTION				
ALLERGIES				
ANEMIA				
ARTHRITIS				
ASTHMA				
BACK PAIN-RECURRENT				
BLEEDING EASILY				
BLOOD IN URINE/HEMATURIA				
BLOODY OR TARRY STOOLS				
BONE FRACTURE OR JOIN INJURY				
CANCER				
CATARACTS				
CHEST PAIN				
CHICKEN POX				
CHRONIC COUGH				
CHRONIC FATIGUE				
COLD NUMB FEET				
COLITIS				
CONSTIPATION				
CROHN'S DISEASE				
DECREASE IN FLOW OR FORCE OF URINE				
DECREASED HEARING				
DEPRESSION/MOODINESS				
DIABETES				
DIARRHEA				
DIFFICULTY SWALLOWING				
DIVERTICULOSIS				
DIZZY SPELLS				
DOUBLE OR BLURRED VISION				

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

CONDITION	PAST	CURRENT	DATE/ AGE ONSET:	DATE/AGE RESOLVED:
DRUG ABUSE/ADDICTION				
EAR INFECTIONS- FREQUENT				
ECZEMA				
EPILEPSY				
EYE PAIN				
FAILING VISION				
FAINTING SPELLS				
FEELINGS OF WORTHLESSNESS				
FOOT PAIN				
GALL BLADDER TROUBLE				
GERMAN MEASLES				
GLAUCOMA				
GOUT				
HEADACHES/MIGRAINE				
HEART DISEASE				
HEART MURMUR				
HEARTBURN				
HEMORRHOIDS				
HERNIA				
HERPES				
HIGH BLOOD PRESSURE				
HIGH CHOLESTEROL				
HOARSENESS- PROLONGED				
IRREGULAR PULSE/HEART PALPITATIONS				
JAUNDICE/ HEPATITIS				
KIDNEY STONES				
LEG PAIN- WHEN WALKING				
LOSS OF APPETITE – RECENT				
LOSS OF CONTROL OF BLADDER-URINATION				
MEASLES				
MEMORY LOSS				
MENTAL ILLNESS				
MUMPS				
NERVOUSNESS				
NOSE BLEED- FREQUENT OR RECURRENT				
NUMBNESS-TINGLING SENSATIONS				
OSTEOPOROSIS				
OTHER:				
PAINFUL URINATION				
PEPTIC ULCER				
PERSISTENT NAUSEA/ VOMITING				
PHOBIAS				
PNEUMONIA/ PLEURISY				
POLIO				
PSORIASIS				
RASHES/HIVES				
RECENT HAIR LOSS				

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

CONDITION	PAST	CURRENT	DATE/ AGE ONSET:	DATE/AGE RESOLVED:
RECENT UNEXPECTED WEIGHT CHANGE				
RHEUMATIC FEVER				
RINGING IN EAR				
SCARLET FEVER				
SEVERE DEPRESSION				
SHORTNESS OF BREATH WHILE ACTIVE				
SHORTNESS OF BREATH WHILE AT REST				
SINUS TROUBLE				
SLEEPING DIFFICULTY				
SORE THROAT- FREQUENT				
STROKE				
SUICIDAL IDEATIONS				
SWOLLEN ANKLES				
THYROID DISEASE				
TREMOR				
TROUBLE WITH CONCENTRATION				
TUBERCULOSIS				
URETHRAL DISCHARGE				
URINATION MORE THAN TWICE AT NIGHT				
URINE/BLADDER INFECTIONS – FREQUENT				
VARICOSE VEINS/PHLEBITIS				
VENEREAL DISEASE				
WHEEZING				

Procedures and Surgeries: □ NONE (If yes, please list all Procedures/Surgeries and indicate when. Ex.: Tonsillectomy-2005

Procedure/ Surgery:	When:

Family History: Does any of the below condition apply to your relative(s)? If so, please mark (x) accordingly.

TYPE	MOTHER	FATHER	SISTER	BROTHER	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcohol Abuse								
Allergies								
Anemia								
Arthritis								
Asthma								
Bleeding Easily								
Cancer: 1.								
2.								
3.								
4.								
Epilepsy								
Glaucoma								
Headache/ Migraine								

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

TYPE	MOTHER	FATHER	SISTER	BROTHER	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Heart Disease								
High Blood Pressure								
High Cholesterol								
Mental Illness								
Osteoporosis								
Severe Depression								
Stroke								
Thyroid Disease								
Other:								

Social History:

ALCOHOL USE:	TYPE (PLEASE CIRCLE)	AMOUNT AND FREQUENCY
□ CURRENT □PAST □ NEVER □ QUIT SINCE: _____		
TOBACCO USE:	TYPE (PLEASE CIRCLE)	AMOUNT AND FREQUENCY
□ CURRENT □PAST □ NEVER □ QUIT SINCE: _____		
SUBSTANCE/DRUG USE:	TYPE (PLEASE CIRCLE)	AMOUNT AND FREQUENCY
□ CURRENT □PAST □ NEVER □ QUIT SINCE: _____		
EXERCISE AND PHYSICAL ACTIVITY:	TYPE (PLEASE CIRCLE)	AMOUNT OF TIME AND FREQUENCY
□ NONE □ REGULAR □ OCCASIONAL		

Pregnancies:

Please complete below for all pregnancies including abortions, miscarriages, etc.

DATE/ TIME	NUMBER OF WKS. PREGNANT	PREGNANCY/ DELIVERY OUTCOME	LENGTH OF LABOR	SEX OF THE BABY	WEIGHT	ANESTHESIA	HOSPITAL
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

Do you have Living Will or Advanced Directive? □ YES □ NO

I certify that the information contained herein is complete and accurate to the best of my knowledge.

_____

Patient Signature Date

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

Employment and Education

Status:	**Work Hazards:**	**Activity Level:**
□ Employed □ Retired □ Disability □ Student □ Part-Time □ Unemployed Other: _____ **Do you operate any hazardous equipment?** Y / N	□ Hazardous Materials □ Repetitive Motion □ Heavy Lifting/Twisting □ Shift/Night Work □ Loud Noises □ Vibration □ Medical/Clinical Work Other: _____	□ Desk/Office □ Moderate Physical Work □ Occasional Physical Work □ Heavy Physical Work Other: _____

Previous Employment/School:	**Highest Education:**	**School Concerns:**
_____ _____ _____ _____ Additional Information: _____ _____	□ None □ Bachelor's Degree □ Elementary School □ Master's Degree □ Adv. Graduate or Ph.D. □ High School/GED □ Middle School □ Some College	□ Learning □ Health □ Social □ Cultural □ Communication □ Other: Additional Information: _____ _____

Home and Environment

Marital Status:	**Lives With:**	**Living Situation:**
□ Single □ Separate □ Married □ Never Married □ Married (Living Together) □ Divorce □ Widowed □ Life Partner □ Annulled Other:_____	□ Self □ Mother □ Children □ Roomate(s)/ Friend(s) □ Family □ Siblings □ Father □ Significant Other □ Foster Family □ Spouse □ Grandparents Other: _____	□ Home/Independent □ Home with Assistance Physical Work □ Homeless/Shelter Other: _____ **Number of Children:** _____

Environment Screening		
Have you experience any abuse in your house hold? _____ _____ _____ _____ _____	**Do you feel unsafe at home?** Y / N **Do you have a safe place to go?** Y / N **Do you have Family/Friends available to help?** Y / N	**Have you notified any Agencies about your abuse?** Y / N **Agency(s)/Others Notified:** _____ _____

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

Nutrition and Health

Briefly write your routine diet:	**Type of Diet:**	**OTHER:**
	□ Regular □ Calorie Restricted □ Diabetic □ Dysphagia Diet □ Ketogenic Diet □ Kosher □ Low Carbohydrate □ Low Fat □ Low Sodium □ Renal □ Total Parenteral Nutrition □ Vegetarian Other: _____	Diet Restrictions: _____ _____ Caffeine intake amount: _____ **Do you want to lose weight?** Y / N

Vitamins/Alternative Health	**Eating Disorders:**	**OTHER:**
Vitamins/Supplements: _____ _____ Uses Alternative Healthcare: _____ _____	□ Bulimia □ Anorexia Nervosa □ Overeating Other: _____ _____ _____	**Sleeping concerns?** Y / N _____ _____ **Feeling highly Stressed?** Y / N _____ _____

Exercise and Physical Activity

Exercises	**Exercise Type:**	**Self Assessment**
How many times per week? □ Never □ 1-2 times □ 3-4 times □ 5-6 times □ Daily Other: _____ __	**Duration (Average # of minutes):** _____ □ Aerobics □ Bicycling □ Organized Team Sports □ PE Class □ Running □ Swimming □ Walking □ Weight Lifting □ Yoga Other: _____	□ Poor Condition □ Fair Condition □ Good Condition □ Excellent Condition Other/Comment: _____ _____ _____

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

Sexual Activity

Activity	Orientation:	Contraceptive Use Details
Are you Sexually Active? Y / N **When were you first active?** **Age:_____** **Number of lifetime partners**: _____ **Number of current partners**: _____	**Self describe orientation:** □ Heterosexual □ Bisexual □ Homosexual □ Transgender Other: _____ **Do you use condoms?** Y / N	□ Abstinence □ Condoms □ Birth Control Implant □ Intrauterine Device □ Birth Control PATCH □ Vaginal Ring □ Birth Control PILL □ None □ Birth Control SHOT Other Contraceptive Use/Comment: _____

History of Abuse	Orientation:	Other Related Concerns:
Have you ever been sexually abused? Y / N Comment: _____ _____ _____	**Self describe orientation:** □ Heterosexual □ Bisexual □ Homosexual □ Transgender Other: _____	

HIPAA Notice of Privacy Practices

Effective Date: September 1, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

***** PLEASE REVIEW THIS NOTICE CAREFULLY *****

OUR OBLIGATIONS

We are required by law to:

- *Maintain the privacy of protected health information*
- *Give you this notice of our legal duties and privacy practices regarding health information about you*
- *Follow the terms of our notice that is currently in effect*

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. *Uses and disclosures of Protected Health Information for marketing purposes; and*
2. *Disclosures that constitute a sale of your Protected Health Information*

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the Practice Administrator. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the Medical Director.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Practice Administrator.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the Practice Administrator. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Practice Administrator. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.brandywinemed.com/onyourvisit.html.

To obtain a paper copy of this notice, please write to: Practice Administrator.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. If you wish to file a complaint with our office, contact our Privacy and Security Officer. All complaints must be made in writing. ***You will not be penalized for filing a complaint****.*

QUESTIONS

If you have any questions about this notice, please contact our Privacy and Security Officer at:

Brandywine Medical Associates
Attn: Melizza Dimat Estrada
Address: 161 Becks Woods Drive, Bear, DE 19701
Phone: 302-266-9166

Thank you for taking time to review our Notice of Privacy Practices.

Last Revised: 03.18.2015

BRANDYWINE
MEDICAL ASSOCIATES

Notice of Privacy Practices

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Brandywine Medical Associates, LLC. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully.

I, _____ acknowledge receipt of the Notice of Privacy Practices.
(Print name)

_____ _____
(Patient or Guardian Signature) *Date*

BRANDYWINE
MEDICAL ASSOCIATES

UNITED
MEDICAL
ACCOUNTABLE CARE ORGANIZATION

United Medical Accountable Care Organization
161 Becks Woods Drive
Bear, DE 19701
Tel. 302-451-5600
Fax 302-451-5614

IMPORTANT INFORMATION ABOUT OUR PRACTICE

Dear Patient,

We want to inform you that our practice proudly participates within the ***United Medical Accountable Care Organization (UMACO)*** network of providers.

What is an ACO? An ACO is a group of doctors, hospitals, and/or other health care providers working together to give you better, more coordinated service and health care. We share important information and resources about your individual needs and preferences.

What are the benefits to me as a patient?

- Accessibility – ACO and Medical Homes are focused on increasing accessibility to treatment for patients.
  - Same day appointments for sick visits
  - Extended office hours during the week and sometimes Saturday hours
  - Medical records can easily be accessed by providers involved with the patient's care.
- Care Coordination and Communication - provide a care team which coordinates efforts to provide better patient care. Communication lines are open among providers as well as between primary care and patients.
- Better Quality Care at a Lower Cost - ACOs are focused upon providing quality outcomes while simultaneously reducing costs. Under ACOs, only necessary tests are run. Reimbursement is based upon quality as opposed to quantity. Additionally, with the emphasis on care coordination, providers can easily check to see what tests/services have previously been performed. This avoids duplication and makes strides toward reducing costs for both unnecessary and duplicate tests/services.
- Reduced Paperwork – An ACO also benefits patients by reducing the amount of paperwork required to be completed. All of the medical records are right there and readily accessible. The emphasis becomes more on verifying pertinent information such as insurance and census data rather than spending hours filling out paperwork and filling out the same paperwork for different providers.
- Primary Care Physician – Under a Medical Home and ACO model, the primary care physician serves as the primary contact for all medical questions, issues, or requests for medical information. The primary care physician is responsible for coordinating care and obtaining all relevant medical information from other providers including specialists, laboratories, and diagnostic imaging. It becomes as easy as one-stop shopping.
- Two-Way Communication – ACOs provide a means of two-way communication with their primary care physician. Patients become involved in the decisions surrounding their healthcare. No longer does the physician just determine treatment without patient input, but it becomes a give and take conversation. Discussions around the different options available take place with the pros and cons of each, whereby the patient and the provider jointly make the decisions as to the best course of treatment.

What should the patient expect as being part of the ACO?

- Care Coordination Communication – Receiving a call and or letter from our care coordination department, which is an extension of our office for follow up appointments, consultation visits with specialist, preventive screenings and others pertaining to your care.
- After Hours Urgent Calls – Calling the office after hours for anything urgent or prior to going to the hospital.
- In-Network Referrals – Preferred in-network providers to be utilized for better coordination of care.
- Cost Education – Access to appropriate, reliable information for the cost of care.

United Medical Accountable Care Organization

Providing Efficient Population Health Management