Delaware
Heart and Vascular Group

Newark office:
94A Omega Drive, Newark DE 19713

Middletown office:
222 Carter Dr, Middletown, DE 19709

Wilmington office:
2500 Grubb Rd Ste 123A, Wilmington, DE 19810

Phone: 302-550-DHVG (3484)

Fax: 302-556-DHVG (3484)

Email: general@delhvg.com

Website: www.delhvg.com

We WELCOME YOU to Delaware Heart and Vascular Group (DelHVG)

We respect your time and we would like to make your visit to our office as efficient as possible.

We are pleased to tell you that our office is located in an area easily accessible by car or bus. We also have ample parking space. Should you need directions, please call us ahead of time.

REMINDERS:

1) CANCELLATIONS / NO SHOW: please call us at least 24 hours before your appointment to avoid a no show fee.

2) FOR YOUR VISIT:

1. Please plan to arrive at least 15 minutes prior to your scheduled appointment.

2. In order for us to expedite your registration process, please complete the following items and send it to us electronically via email general@delhvg.com 3 days before your scheduled appointment:

- ***Patient Registration Form, completely filled-out and signed***
- ***Financial Policy Form, completely reviewed and signed***
- ***Medical History Form, completely filled-out and signed***
- ***Consent Form, completely filled-out and signed***

3) To bring at the time of your visit:

- ***Valid insurance card(s)***
- ***Photo ID, preferably state issued/ student ID for minor***
- ***Co-pay, if it applies to your insurance***

******PLEASE BE AWARE THAT FAILURE TO COMPLETE AND BRING THE ABOVE ITEMS WITH YOU MAY RESULT TO RESCHEDULING YOUR APPOINTMENT* *****

4) Registration through our IQ Health Patient Portal

- **Access to our online patient portal is a must in order to efficiently communicate with our office.**
- **Your email address will be required for the set up.**
- **This portal allows you to be able to do the following:**
  - **v View Your Visit Summary/Test Results**
  - **v Request an appointment**
  - **v Request medication refills**
  - **v Update demographic information**
  - **v Send and receive non-urgent messages**
  - **v Keep track of your health**

To better serve you, please review and complete the documents carefully.
Please do not hesitate to call us if you have any questions.

Thank you for choosing us for your cardiovascular care!
We look forward to meeting with you soon!

Delaware
Heart and Vascular Group

PATIENT DEMOGRAPHIC INFORMATION

Last Name:	First Name:	MI:	Gender:

Street Address:	City:	State:	Zip Code:

Marital Status:	Social Security #:	Date of Birth:	Age:	Occupation:

Home Phone:	Cell Phone:	Work Phone:	Email Address:

Responsible Party:	Date of Birth:	Social Security #:
		- -

Home #	Work #	Cell #	Relationship to Patient:

Address:		**Employer:**
City/State/Zip:		

Emergency Contact:	Relationship to Patient:

Phone: Home #	Work #	Cell #

Insurance Carrier	Primary Holder Name	Date of Birth:

Effective Date	ID #	Group #

AUTHORIZATION AND ACKNOWLEDGEMENT

Please initial and sign at the bottom:

_____ **Authorization and Assignment of Benefits:** I hereby give permission to DelHVG and its employees, agents, and medical providers to release medical information to health plans, health organizations, governmental agencies, and other entities charged with fiscal responsibility for the payment of medical services rendered to me. I hereby authorize payment of the medical benefits otherwise payable to me to be directed to DelHVG. I consent to have any monies received by the provider of services on my behalf to be applied to my outstanding accounts. I assume full responsibility for payment of any charges for the medical services provided. I understand that any or all of my medical information may be electronically submitted to any or all treating providers, hospitals, and/or health care entities. I permit a copy of this authorization to be used in place of the original.

_____ **HIPAA Privacy Acknowledgement:** I hereby acknowledge that I have received and reviewed the NOTICE OF THE PRIVACY PRACTICES from DelHVG.

_____ I ACKNOWLEDGE THAT MY SPECIALTY PROVIDER IS PART OF THE UMACO NETWORK OF INDEPENDENTLY OWNED PRIMARY CARE AND SPECIALTY PRACTICES RECOGNIZED AS ONE ENTITY PROVIDING QUALITY CARE TO PATIENTS.

Patient or Guardian Signature: _____ Relationship: _____ Date: _____

MEMBER OF THE UNITED MEDICAL ACO NETWORK

Our Financial Policy

Thank you for choosing us as your medical provider. We are committed to provide 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, understand, and sign below** prior to receiving treatment from us.

You are expected to present your current insurance card(s) at each visit. Any minor patient must be accompanied by an adult representative who has assumed financial responsibility for the minor patient. To protect patients from identity theft, we also ask that you present a photo identification card at time of visit. It is your responsibility to advise us of any change in your address, telephone number, or employer information.

Your insurance is a contract between you and your insurance company. We are not a party to the contract. It is very important that you understand the provisions of your policy. We will file an insurance claim as a courtesy to our patients however this does not release you of your financial responsibility. If you have more than one insurance plan, it is your responsibility to inform us regarding the order of how we should file your claim and coordinate with your insurances as well.

We will collect your co-payment, deductible, balances, or charge for non-covered services at the time of your visit. We will not be responsible for any disputes between you and your insurance company regarding copays, deductible, covered charges, etc. other than to supply factual information.

Patients with High Deductible Plans will be asked to pay a pre-payment deposit of $75 prior to service. If deductible has been satisfied with verification from the carrier, only the co-payment is required, if applicable.

We cannot guarantee payment of all claims. If your insurance pays only a portion of the bill or rejects your claim, you will be 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.

If you do not have insurance, or we do not participate with your insurance company, you will be expected to pay in full at the time of visit.

We accept cash, checks, or major credit cards. It is our policy to charge a $35 fee for returned check.

We follow the fee schedules set forth by the Board of Professional Regulation for charging for reproduction of medical records. We charge a $30 fee for completion of forms. (ie: FMLA forms)

When you schedule an appointment, time is specifically allocated for you. We ask that you notify us at least 24 hours in advance if you are unable to keep your appointment to avoid a $25 “No Show” fee for established patient and $50 “No Show” fee for new patient. If three appointments are missed, you will be dismissed from the practice for non-compliance.

We reserve the right to take lawful actions including referring your account to a collections agency and report to one or more credit bureaus for non-payment.

Thank you for taking time to review our financial policy. If you have any questions, please ask to speak with our Practice Manager.

Patient/Authorized Representative Name: _____

Signature: _____ Date: _____

Patient Consent for Use and Disclosure of Protected Health Information

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

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

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

Name	Relationship	Home #:	Work #:	Cell #:

Please indicate name, contact numbers, and relationship of individuals to whom DelHVG may release PHI.

I have the right to review the Notice of Privacy Practices prior to signing this consent. DelHVG reserves the right to revise its Notice of Privacy Practices at anytime. A written copy of our Notice of Privacy Practices may be obtained by forwarding a written request to our office.

CONSENT FOR CALLS TO HOME

With my consent, DelHVG may call my home or other designated location and leave message on my voice mail or with a person in reference to any item that may assist DelHVG 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, DelHVG may mail to my home or other designated location any item that may assist DelHVG in carrying out TPO such as appointment reminder cards and patient statement as long as they are marked CONFIDENTIAL.

CONSENT FOR E-MAIL

With my consent, DelHVG may e-mail to my designated e-mail address any message in reference to any item that may assist in my care.

DelHVG may contact me for TPO use, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

I have the right to request that DelHVG restricts how it uses or discloses my PHI to carry out the TPO, However, DelHVG 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 DelHVG's use and disclosure of my PHI to carry out TPO.

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

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Patient's Name — Date

_____

Printed Name of Patient or Legal Guardian

REMOTE PATIENT MONITORING ENROLLMENT FORM

Patient Name: DOB:

Thank you for joining the DelHVG Remote Patient Monitoring Program (RPM). Through this program, we will monitor your blood pressure remotely using the provided blood pressure monitoring device and gateway. Our objective is to deliver personalized and timely care to optimize your blood pressure and overall cardiovascular health.

By agreeing to participate, you are consenting to the following terms:

- Blood pressure readings will be conducted daily, and you must complete at least 16 days of readings within 30 days. Failure to do so may result in unenrollment from the program, requiring the return of the device.
- Your insurance will be charged monthly for the Remote Monitoring Program. Regardless of monthly office visits, you are responsible for payment, including any applicable copays depending on your insurance. We will monitor your monthly blood pressure readings and care management time.
- Your health information may be shared electronically with your healthcare team for optimal care coordination. All data collected will be treated with utmost confidentiality and will be accessible only to authorized healthcare providers involved in your care.
- Prompt communication of health concerns or changes to the healthcare team is expected.
- Disclosure of enrollment in similar remote blood pressure monitoring programs elsewhere is mandatory.
- In case of device damage, loss, or malfunction, you may be billed $125.00 for device replacement.

I understand that my participation is voluntary, and I reserve the right to withdraw without affecting my regular medical care. Either party can discontinue the service at any time, with the termination effective at the end of the calendar month.

I, _____, acknowledge, understand, and agree to these terms.

_____ _____

Patient Signature Date

CHRONIC CARE MANAGEMENT/PRINCIPAL CARE MANAGEMENT CONSENT FORM

Patient Name: DOB:

I hereby consent to participate in the Chronic Care Management (CCM) Program/Principal Care Management (PCM) Program at the DelHVG.

Program Overview: The CCM/PCM Program is designed to enhance the quality of care for patients with chronic/cardiac conditions by providing additional support and coordination. This program involves regular communication and coordination of care between healthcare providers, including physicians, advanced provider clinicians, and other healthcare professionals.

Program Components:
- Regular follow-up calls or electronic communications to assess and discuss your health status.
- Medication management and reconciliation.
- Coordinate care with other healthcare providers involved in your treatment.
- Assistance with appointment scheduling and reminders.

Patient Responsibilities: By participating in the Program, I understand and agree to:
- Respond promptly to communication attempts from the healthcare team.
- Provide accurate information about my health status, medications, and treatments.
- Notify the clinic of any changes in my contact information.
- Collaborate with the healthcare team to actively manage my chronic conditions.

Confidentiality: I understand that my personal health information will be handled in accordance with applicable privacy laws and regulations. The information shared will be kept confidential.

Voluntary Participation: Participation in the Program is voluntary, and I may withdraw my consent at any time without affecting my regular healthcare services.

Patient Consent: I have read and understood the information about the Program at DelHVG. I agree to participate in the program and consent to collecting and using my health information for the purposes outlined.

I, _____, acknowledge, understand, and agree to the contents of this form.

_____ _____

Patient Signature Date