UNITED MEDICAL CLINIC

We strive for your family's
health & wellness!

www.umclinic.net

Call us at (302) 261-5600

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www.umclinic.net

Dover

1113 S. State Street
Suite #202
Dover, DE 19901
Fax 302-836-4302

Becks Woods

121 Becks Woods Dr.
Suite 100
Bear, DE 19701
Fax 302-836-4302

Smyrna

38 Deak Drive
Smyrna, DE 19977

Fax 302-653-9563

Wilmington

1021 Gilpin Ave.
Suite 203
Wilmington, DE 19806
Fax 302-836-4302

Our on-call doctors are available after hours;
just call one of our office locations near you.

We WELCOME YOU to our practice!

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 $50 no show fee.
2) **FOR YOUR VISIT:**
    1. Please plan to arrive at least 30 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 IQ Health 1 WEEK 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*
        - *List of* ***all your current medications***
3) ***Please send below documents via IQ Health:***
    - *Valid* ***insurance card****(s)*
    - ***Photo ID****, preferably state issued/ student ID for minor*
4) If applies with your insurance, **Copay** will be collected at the time of the visit

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

5) ***Registration through our IQ Health Patient Portal is required***
    - 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:
        - ❖ View Your Visit Summary/Test Results
        - ❖ Request an appointment
        - ❖ Request medication refills
        - ❖ Update demographic information
        - ❖ Send and receive non-urgent messages
        - ❖ Keep track of your health

Enclosed you will find important documents about our practice.
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 as your primary care provider!
We look forward to meeting with you soon!

PATIENT DEMOGRAPHIC INFORMATION

Today's Date:	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 United Medical Clinic, LLC 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 United Medical Clinic, LLC. 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.

_____ **Financial Policy Acknowledgement:** I hereby acknowledge that I have received and reviewed the FINANCIAL POLICY of United Medical Clinic, LLC. I understand that it is my responsibility to provide United Medical Clinic, LLC with my current demographic, insurance, and medical information.

_____ **HIPAA Privacy Acknowledgement:** I hereby acknowledge that I have received and reviewed the NOTICE OF THE PRIVACY PRACTICES from United Medical Clinic, LLC.

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

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 demographic and insurance information such as address, telephone number, email address, employer information, Insurance information etc.

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 $25 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. Further, when there are multiple No Show and/or cancellation, our practice has the right to ask for $250 deposit in order to keep providing future services.

We reserve the right to take lawful actions including referring your account to a collection’s 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: _____ _____

(Revised: 07/22)

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

With my consent, UNITED MEDICAL CLINIC, LLC 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 UNITED MEDICAL CLINIC, LLC may release PHI.

I have the right to review the Notice of Privacy Practices prior to signing this consent. UNITED MEDICAL CLINIC, LLC 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, UNITED MEDICAL CLINIC, LLC 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 UNITED MEDICAL CLINIC, LLC 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, UNITED MEDICAL CLINIC, LLC may mail to my home or other designated location any item that may assist UNITED MEDICAL CLINIC, LLC 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, UNITED MEDICAL CLINIC, LLC may e-mail to my designated e-mail address any message in reference to any item that may assist in my care.

UNITED MEDICAL CLINIC, LLC 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 UNITED MEDICAL CLINIC, LLC restricts how it uses or discloses my PHI to carry out the TPO, However, UNITED MEDICAL CLINIC, LLC 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 UNITED MEDICAL CLINIC, LLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that UNITED MEDICAL CLINIC, LLC has already made disclosure in reliance upon my prior consent. If I do not sign this consent, UNITED MEDICAL CLINIC, LLC 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

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

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 Medical History Form** continued…*

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 Medical History Form** continued…*

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.								
Diabetes								
Epilepsy								

Glaucoma								
Headache/ Migraine								

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	HOSP
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 Medical History Form** continued…*

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 □ Heavy Lifting/Twisting □ Loud Noises □ Medical/Clinical Work □ Repetitive Motion □ Shift/Night Work □ Vibration Other: _____	□ Desk/Office □ Occasional Physical Work □ Moderate Physical Work □ Heavy Physical Work Other: _____

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

Home and Environment

Marital Status:	**Lives With:**	**Living Situation:**
□ Single □ Married □ Married (Living Together) □ Life Partner □ Separate □ Never Married □ Divorce □ Widowed □ Annulled Other:_____	□ Self □ Children □ Family □ Father □ Foster Family □ Grandparents □ Mother □ Roomate(s)/ Friend(s) □ Siblings □ Significant Other □ Spouse 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 Medical History Form** continued…*

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 Medical History Form** continued…*

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: _____	

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.

What is a Patient Centered Medical Home?

United Medical Clinic is dedicated to providing our patients with the highest standard of care. We believe that our patients receive the best possible care when they participate in their medical treatment. A **Patient Centered Medical Home** is a partnership between an informed patient and authorized representatives and a physician-led care team.

As your medical home, we will:

- ✓ Allow you to select a personal clinician and care team who will know you
- ✓ Help improve your overall well-being including behavioral health by learning about you, your family, life situation, and health preferences
- ✓ Respect your privacy and keep your information confidential unless you give us written permission or it is required by law
- ✓ Inform you about your health condition in a way you can understand
- ✓ Take care of your short term illness, long term chronic disease, and preventive care
- ✓ Collaborate with your other health care providers to coordinate your care
- ✓ Notify you of your test results using our patient portal or by phone
- ✓ Keep you up to date on all your vaccines and preventive studies
- ✓ Remind you when tests are due to help prevent delays in your diagnosis and treatment
- ✓ Use current evidence-based guidelines and provide self-care management support
- ✓ Give the care that meets your needs and fits your goals and values
- ✓ Discuss and review your care plan and provide educational resources
- ✓ Give you information about classes, support groups, or other services that can help you learn more about your condition and stay healthy

Other important information:

- ✓ We have extended hours in our Bear location where physicians can access your electronic medical records.
- ✓ Our on-call physicians are available to speak with after-hours for urgent needs by calling our main office numbers
- ✓ We encourage you to use IQ Health, our secured patient portal to access your health information and communicate with us for non-urgent matters during and after office hours.

We trust you, our patient to:

- ✓ Participate as a full partner in your care
- ✓ Understand your health condition and let us know if there is something you do not understand
- ✓ Inform us about your health needs and concerns
- ✓ Take your medications as prescribed
- ✓ Come to each visit with any updates on medications, dietary supplements, or remedies you are using and let us know if you need a refill
- ✓ Keep us up-to-date with changes in your personal, family, medical and social history
- ✓ Inform us if you were seen by any other provider or at any facility and/or if you had any test ordered and/or medications prescribed by them
- ✓ Ask other providers to send us your reports
- ✓ Know what your insurance covers and let us know if a service is not covered; pay your share of any fees
- ✓ Keep your scheduled appointments and notify us at least 24 hours prior if you need to cancel
- ✓ Call us if you do not receive your test results within 2 weeks
- ✓ If possible, inform us if you are going to the Emergency room so that we can assist with your treatment
- ✓ Follow the care plan that you have agreed upon, or let us know why you cannot so we can try to help and change the plan
- ✓ Give us feedback on how we can improve our services

Either you or your doctor may end this partnership at any time. If you choose to end this partnership, please notify us and tell us why. Thank you for choosing us as your health partner! Please acknowledge below.

Patient Centered Medical Home

What is a Medical Home?

A **Medical Home** is not a place or somewhere you would go, it simply means an applied **team-based approach** by your primary healthcare provider, where integrated care can help maximize your overall healthcare outcome!

The Patient Centered Medical Home (PCMH) model practice emphasizes in care coordination and improved communication in order to provide **quality care**, **lower medical costs**, and provide an **excellent patient care experience**.

How does this affect you?

As part of our commitment to provide you with the highest standard of care, by practicing a team-based approach for better care and communication as well as using innovative and secured tools for improved health care access. We partner with you and collaborate with your other providers to achieve the best quality tailored care we can offer!

Did you know?

You can prolong your life and lower the cost of your healthcare, just by taking control of your health. Having an annual exam with your provider can help assess and improve your overall health and well-being.

Our role as your trusted HEALTHCARE TEAM

- Provide a safe and healthy healthcare environment.
- Partner with you in making your healthcare decisions.
- Coordinate with you, your authorized representatives, and other healthcare providers.
- Keep you informed and on-track by providing:
  - *Health Coaching*
  - *Self-Care Management Support*
  - *Health resources*
  - *Preventive care*
  - *Tailored care*

Your role as a PATIENT

- Communicate closely with us.
- Keep us up-to-date with your medications, immunizations, allergies, conditions, tests, consultations, and hospitalizations.
- Advise of any changes about you and your families' medical history.
- Inform and authorize your other providers to coordinate with us.
- Participate in decisions about your health.
- Follow treatment plans and self-care management directions.
- Speak up and ask questions!

To learn more about PCMH, please visit us at www.umclinic.net

Meet Our Care Teams

At United Medical Clinic, we formed our care teams in order to provide tailored care for each of our patient needs. Every patient is assigned to a care team.

What is a Care Team?

A care team is group of health professionals and support staff working together with the patient to achieve a common purpose. As a patient, YOU are the team captain of your team!

Why Patient Care Teams?

Patient-centered care teams deliver care that is respectful of and responsive to their individual patient preferences, needs, and values.

CARE TEAM ROLES

Primary Care Provider (PCP)

Your PCP is the physician who knows you best and who is ultimately responsible for your overall medical care. He or She prescribes medications and orders any necessary screening and diagnostic studies, referrals to specialists, and any other medical treatment. Your PCP also discusses and reviews your care plan and goals with you.

Physician Assistant (PA)

Your PA is a specially trained professional who works collaboratively with your physician. He or she can diagnose and treat many of the same conditions as your PCP and can order tests and prescribe medications. They also work very closely with your PCP in reviewing your care plan and goals with you.

Medical Assistant (MA)

Your MA is the person that escorts you from the waiting room to the exam room, takes your vital signs and updates your clinical information in your medical record. They can also perform certain diagnostic tests like EKG, draw your blood, and administer injections.

Patient Service Coordinator (PSC)

Your PSC is the person who obtains your current demographic and insurance information. He or she also schedules your appointments, works with your insurance, and helps coordinate your care across settings by following up with you after you are seen by another provider or reminds you regarding studies that you need done.