Welcome to our practice!

*Established in 1997 by founder **Jona Gorra, MD FACP**, DC Medical Services is committed to care for the growing community in the Delaware Sussex County for over 10 years. Seaford Internal Medicine, established in 2006, also shares the same passion and professional care. At DC Medical Services and Seaford Internal Medicine, our physicians are board-certified in their fields, providing preventative care, treatments for common conditions and infectious diseases.*

Our Office Contact & Locations

10 W. Laurel St. Georgetown, DE **T** 302.855.0915 **F** 302.855.0914 302.855.0994	1501 Middleford Rd. Seaford, DE **T** 302.629.4569 **F** 302.628.4669	1507 Middleford Rd. Seaford, DE **T** 302.629.4569 **F** 302.536.7594	9109 Middleford Road. Seaford, DE 19973 T 302.629.9200 F 302.629.9204
Monday – Friday: 9:00am – 6:00pm	***Monday – Friday:*** 8:00am – 5:30pm	***Monday – Friday:*** 8:30am – 5:30pm	***Monday-Friday:*** 8:30am - 5:30pm

www.dcmedicalde.com
www.seafordinternalmedicine.com

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!

Meet Our Care Team

At Seaford Internal Medicine/DC Medical Services, 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.

Nurse Practitioner (NP)
Your NP 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.

Patient Information

Patient Name: _____ **Date:** _____
Street Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Social Security #: _____ **Date of Birth:** _____ **Marital Status:** _____ **Sex: M F**
Home Phone #: _____ **Work #:** _____ **Cell #:** _____
Employer: _____ **Occupation:** _____
Emergency Contact: _____ **Relation to Patient:** _____
Home Phone #: _____ **Work #:** _____ **Cell #:** _____
Pharmacy Name: _____ **Location:** _____
Email Address: _____

Guarantor Information: If Other Than Patient (Required if patient is a minor/dependent)

Guarantor Name: _____ **Relation to Patient:** _____
Street Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Social Security #: _____ **Date of Birth:** _____ **Marital Status:** _____ **Sex: M F**
Home Phone #: _____ **Work #:** _____ **Cell #:** _____

Insurance Information

Primary Insurance: _____ **Effective Date:** _____
Policy Holder Name: _____ **Relation to Patient:** _____
Social Security #: _____ **Date of Birth:** _____ **Copay: $** _____
Secondary Insurance: _____ **Effective Date:** _____
Policy Holder Name: _____ **Relation to Patient:** _____
Social Security #: _____ **Date of Birth:** _____ **Copay: $** _____

Authorization for the Release of Medical Information/Assignment of Benefits

I give permission to ***Seaford Internal Medicine, Inc. (SIM)/D.C. Medical Services, LLC (DCMS)*** and its employees, agents and medical providers to release medical information to insurance carriers, 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 ***SIM/DCMS*** or appropriate provider. 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 my medical information may be electronically submitted to any or all treating physicians, hospitals and/or health care entities.

X_____

Signature **Relation to Patient** **Date**

MEDICAL HISTORY

Patient Name: _____ **Age:**_____ **Date:** _____
Chief Complaint: _____
History of Present Illness: _____
_____
_____

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ **No** ☐ **Yes**
(If yes, please list names of medicine and type of reactions):
_____
_____

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

Please circle if you have had problems with or are presently complaining of any of the following:

1. Abdominal discomfort	13. Colitis	26. Heart disease	39. Rheumatic fever
2. Alcohol abuse	14. Constipation	27. Hemorrhoids	40. Skin diseases
3. Anxiety	15. Depression	28. Hepatitis or jaundice	41. Shortness of breath
4. Anemia	16. Diabetes	29. High blood pressure	42. Swollen ankles
5. Arthritis	17. Diarrhea	30. Indigestion	43. Thyroid disease
6. Asthma	18. Difficulty urination	31. Kidney diseases	44. Tuberculosis
7. Blood disorders	19. Drug abuse	32. Kidney stones	45. Ulcers
8. Blood in stool	20. Frequent urination	33. Lightheadedness	46. Unexplained weight gain/loss
9. Bronchitis	21. Gall bladder disease	34. Low back pain	
10. Cancer	22. Gout	35. Nausea	47. Venereal diseases
11. Change in bowel habits	23. Hay fever	36. Palpitations	48. Vomiting
12. Chest pain/chest Tightness	24. Headache	37. Persistent	49. _____
	25. Head or neck radiation	38. Pneumonia	50. _____

_____
_____
_____
_____
_____
_____

Gynecologic and Obstetric History

Age at onset of periods: _____ Frequency: _____ Length of period: _____
Pregnancies: _____ Births: _____ Miscarriages: _____
Prolonged or abnormal bleeding: ☐ No ☐ Yes (Please Describe): _____
Leakage of urine: ☐ No ☐ Yes (Please Describe): _____
Pelvic pain: ☐ No ☐ Yes (Please Describe): _____
Abnormal discharge: ☐ No ☐ Yes (Please Describe): _____
History of abnormal Pap smear ☐ No ☐ Yes (Type of treatment): _____

Patient Name: *Date:* / /

Please List and Supply the Dates of:

Operations: _____ _____ _____

_____ _____ _____

Hospitalizations other than for surgery: _____ _____

_____ _____ _____

Immunization history—have you had: **Pneumovax immunization?** ☐ **No** ☐ **Yes** **When?** _____

Hepatitis B? ☐ **No** ☐ **Yes** **When?** ___ **Flu immunization?** ☐ **No** ☐ **Yes** **When?** _____

Other? _____ ☐ **No** ☐ **Yes** **When?** _____ **Tetanus immunization?** ☐ **No** ☐ **Yes** **When?** _____

When was your last:

Pap smear? _____ Breast exam? _____ Stool check for blood? _____

Mammogram? _____ Cholesterol check? _____ Prostate exam? _____

FAMILY HISTORY

Has any members of your family (including parents, grandparents, and siblings) ever had the following?

Illness		Which family members?	Approx.. age when diagnosed
Cancer (describe type)	☐ No ☐ Yes		
Hypertension (High blood pressure)	☐ No ☐ Yes		
Heart disease	☐ No ☐ Yes		
Diabetes	☐ No ☐ Yes		
Strokes	☐ No ☐ Yes		
Mental disease (anxiety, depression, etc.)	☐ No ☐ Yes		
Drug or alcohol addiction	☐ No ☐ Yes		
Glaucoma	☐ No ☐ Yes		
Bleeding diseases	☐ No ☐ Yes		

Other: _____

MEDICATIONS (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose

PREVENTIONS

Do you wear seatbelts?	☐ No ☐ Yes	If no, why not? _____
Do you wear a bike helmet?	☐ No ☐ Yes	☐ N/A
Do you smoke?	☐ No ☐ Yes	If yes, how many packs per day? _____
Do you drink alcoholic beverages?	☐ No ☐ Yes	If yes, how much per week _____
Do you drink coffee?	☐ No ☐ Yes	If yes, how many cups per day? _____
Do you drink tea?	☐ No ☐ Yes	If yes, how many cups per day? _____
If there is a gun in your home, is it out of children's reach and unloaded?	☐ No ☐ Yes	☐ N/A
Do you use drugs? (marijuana, cocaine, crack, etc.)	☐ No ☐ Yes	If yes, explain: _____
Have you ever engaged in any activity which has put you at risk of getting AIDS?	☐ No ☐ Yes	If yes, explain: _____
Do you wish to be tested for AIDS?	☐ No ☐ Yes	
Have you ever worked with chemicals, paints, asbestos, or other hazardous material?	☐ No ☐ Yes	If yes, explain: _____
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	☐ No ☐ Yes	
Do you ever feel afraid of your partner?	☐ No ☐ Yes	
Do you have a "living will"?	☐ No ☐ Yes	
Do you have a donor card?	☐ No ☐ Yes	

Method of birth control? _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 among the multiple healthcare providers who may be involved in that treatment directly and indirectly**
- **Obtain payment from third-party payers**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have received, read and understand your *Notice of Privacy Practices* containing a more complex description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations, I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

CREDIT CARD AUTHORIZATION

I authorize *Seaford Internal Medicine, LLC/D.C. Medical Services, LLC* to maintain my credit/debit card on file. I understand the card will be used if my account has been delinquent for more than 90 days and I have not made any effort to make payment arrangements.

Cardholder Signature **Date**

Patient's Name:	**Account No.**
Cardholder's Name:	**Phone:**
Cardholder's Address:	

City:	**State:**	**Zip:**
_____ VISA _____ MC		
Credit Card Number:	**Exp:**	**CVV:**

Consent To Release Information

Patient_____ **DOB**_____
Physician Releasing Records: **Physician/person to Receive records:**

Name:_____ **Name:**_____
Address:_____ **Address:**_____
City/State/Zip:_____ **Phone/Fax:**_____

Medical Information To Be Sent:

____ Entire medical record, 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.

____ Records of care from ____ 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.

____ Records of care from ____ 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.

If deemed necessary by DR. _____, I authorize this information to be sent via fax transmission.

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

I authorize medical information to be released as indicated above. I understand that I may revoke my consent at any time by providing written consent to the above named party. I understand that there may be a charge involved when copies are requested.

_____ _____
Patient or Legal Guardian Date

_____ _____
Witness Date

IQHealth

Welcome to Your Secure Patient Portal!

Dear Patient,

We are excited to offer you a new informational system through United Medical Physicians called **IQHealth**. This system allows web based interactions between patients and our office. You will be able to:

View your test results
Request an appointment
Request medication refills
Update demographic information
Send and receive messages
Keep track of your health

In order to take advantage of this new feature, we will need your email address. You will then receive a one-time secure email invitation from **IQHealth.com** to set up an account. Simply click on the link in your email and follow the prompts to activate your account. For any questions or concerns please contact the office for assistance.

We hope this new system will make communication with our office easier and more convenient. If you choose not to participate, you may still contact the office via telephone and mail.

Sincerely,

DC Medical Services, LLC and Seaford Internal Medicine, LLC

I wish to participate

Name: _____

Email Address: _____

Last 4 digits of SSN: _____

I do not wish to participate

Name: _____

DCMS/SIM 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 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 Name: _____ DOB: _____

_____

Patient Signature Date

OFFICE POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them on your/child's behalf. IF THE INSURANCE COMPANY *THAT* YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
2. If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for the visit. If your insurance is through an auto accident you must provide the office with the name of the insurance company, the claim number, the adjustors name and phone number, and any information pertaining to this. You are also responsible for completion of the PIP application.
3. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
4. You are responsible for any balance on your account. All self-pay patients are required to pay the FULL BALANCE at the time of visit. ALL COPAYS and balances are required to be paid at time visit. If you do not have copay, you will be asked to reschedule your appointment.
5. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered. It is also your responsibility to confirm that a prior authorization has been processed.
6. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
7. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
8. Co-payments are due at time of service. A $5.00 processing fee (or service fee) will be charged in addition to your co-payment if the co-payments is not paid at time of service or by the end of the next business day.
9. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 10 business days of your receipt of your bill.
10. If previous arrangements have not been made with our finance office; any balance over 90 days will be forwarded to a collection agency. The office will be contacting you by phone and will be leaving a message if you are not available. You will be responsible for collection fees and charges including the 30% being charged by the collection agency.
11. If you participate with a high-deductible health plan, we require a copy of the health savings account debit/credit card or a personal credit card remain on file. There are addenda to this financial policy, which are signed separately.
12. We require 24-hour notice for canceling any appointment.
13. A $25 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
14. We charge a fee for copy or transfer of medical records. There is a fee for any forms completed. Payment is due when the forms are dropped off. We have a 7 - business day turnaround time for forms. We charge $100 per page if the form is needed to be completed within 24 hours.
15. Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days. It is your responsibility to know if a selected specialist participates in your plan. Remember your primary care physician must approve referrals before being issued.
16. Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. Not all plans cover annual healthy physicals or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of visit.
17. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.
18. We accept cash, checks, MasterCard, Visa, Discover and debit cards.
19. All non-emergency messages for the doctors are reviewed at the end of the day after the doctors have finished seeing patients.
20. All controlled substances and antibiotics will require an appointment for each and every refill. No controlled substances or antibiotics will be dispensed without an appointment. There will be no exception regarding this policy.

OFFICE POLICY ACKNOWLEDGEMENT

I have read and understand the office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s) _____

_____

Responsible party member's name Relationship

_____

Responsible party member's signature Date