DMC PRIMARY CARE

www.DMCPrimaryCare.com 603-537-1300

Dear New Patient,

Welcome to DMC Primary Care! We look forward to providing you and your family with high-quality primary care in our Bedford, Concord, Derry, Dover, Goffstown, Londonderry, Raymond, and Windham offices.

We strive to provide easy access to healthcare that fits your busy schedule with:

- Same day urgent appointments in every primary care clinic, often within two hours of calling
- Saturday hours in our Bedford and Londonderry practices
- **Walk in acute care <u>for DMC patients only</u> in Bedford, Concord, and Londonderry**
- One central phone number to reach all offices and departments: 603-537-1300
- Phones answered live:
  - Monday – Thursday 7:30 am – 7:30 pm
  - Friday 7:30 am – 5:00 pm
  - Saturday 8:00 am – 2:30 pm
- Extended office hours (vary by practice location):
  - Monday – Thursday 8:00 am – 8:00 pm
  - Friday 8:00 am – 5:00 pm
  - Saturday (Bedford & Londonderry) 8:00 am – 3:00 pm
- Providers on call 24/7
- Online self-scheduling at www.DMCPrimaryCare.com
- Online bill pay at DMCPrimaryCare.com
- **Express Check-In:** Complete your visit paperwork ahead of time at your convenience with "Pre-Check." And then, when you arrive for your appointment, you can check in at an easy-to-use kiosk or by scanning a QR code with your mobile phone

- **FollowMyHealth (FMH) patient portal: Join FMH with the email invite you received or go to www.DMCPrimaryCare.com and click on "FMH Patient Portal." In FMH you can:**
  - **View your health summary**
  - **Message your healthcare team**
  - **Get lab results**
  - **Request medication refills**
  - **View upcoming appointments**
  - **View and pay your bill**
  - **More**

  If you need help setting up an FMH patient portal account, please call us at 603-537-1300, or call the FMH Technical Support line at 888-670-9775.
- Independent on-site diagnostic imaging with Derry Imaging Center
- Independent laboratory services on site
- Access to specialized chronic care management at DMC for the cost of a regular office co-pay

This packet contains several forms for you to sign: New Patient Information Form, Authorization to Use/Disclose Health Information (Medical Release), Patient Code of Conduct Policy, No Show Policy, Financial Agreement, General Consent for Treatment, New Patient Acknowledgement and Consent, Preventive Health Visits/Additional Medical Services, and Communication Preferences and Consent. Please review at your earliest convenience. **Please be sure to fill out and return the enclosed Medical Release Form prior to your first appointment. Finally, please be sure to choose a DMC provider as your PCP <u>with your insurance company</u> before your visit.**

Thank you again for choosing DMC Primary Care.

Yours in good health,

DMC Primary Care

NEW PATIENT INFORMATION

PATIENT INFORMATION:

First Name: _____

Last Name: _____

Date of Birth: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Cell Phone Number: _____

Home Phone Number: _____

Email: _____

PARENT INFORMATION (if applicable):

****Please include information for <u>BOTH</u> parents.**

Mother's First Name: _____

Mother's Last Name: _____

Mother's Cell phone number: _____

Father's First Name: _____

Father's Last Name: _____

Father's Cell phone number: _____

GUARDIAN INFORMATION (if applicable):

****Please provide guardianship paperwork.**

Guardian's First Name: _____

Guardian's Last Name: _____

Guardian's Cell phone number: _____

MEDICAL APPOINTMENT
NO SHOW POLICY

Patient Name (First and Last): _____ Date of Birth: _____

In order to accommodate all patients, if you need to cancel or reschedule an appointment, please do so as soon as possible, preferably **at least 24 hours** before your appointment. Failure to attend your appointment without contacting us by phone or responding to the reminder notification is considered a "no-show." Below is DMC's policy regarding no-show's.

New patients who have never been seen at DMC: If the first appointment is missed, the medical record will be deactivated without any further notification, and the individual will **not** be considered a patient.

Patients who have established care at DMC, including specialty services:

First No-Show: Patients who no-show their first appointment will receive a reminder letter.

Second No-Show: Patients who no-show a second appointment within the same 12-month period will receive a final warning letter. A **$50 fee** will be charged to your account. You will be notified of the charge, and payment is expected prior to your next visit. Insurance will not cover this fee.

Third No-Show: Patients who no-show a third appointment within the same 12-month period will be discharged from DMC. Discharged patients will receive a discharge notification letter via certified mail.

We provide automated call, text, and email reminders 2-3 days prior to all appointments. However, even if you do not receive a reminder, the above policy will remain in effect; our reminder system is only provided as a courtesy.

By signing below, I acknowledge the DMC Primary Care No-Show Policy:

_____ _____

Signature of Patient/Legal Representative: Date

_____ _____

Print Name of Legal Representative (if applicable) Relationship to Patient

PATIENT FINANCIAL AGREEMENT

Patient Name (First and Last): _____ Date of Birth: _____

Thank you for choosing DMC Primary Care for your healthcare needs. In order to provide services, we ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

INDIVIDUAL FINANCIAL RESPONSIBILITY: You are financially responsible to pay for all charges incurred for services and procedures received at DMC Primary Care (DMC) and agree to the following:

Proof of Insurance: It is your responsibility to provide DMC with a copy of your current health insurance card(s), and to update DMC as soon as possible regarding any changes to your insurance(s).

Non-covered Services: If you are provided a service that is not covered by your insurance plan, you are responsible for any remaining balances. There may be circumstances when a separate signed waiver may be requested by DMC.

Uninsured: If you do not have insurance, you will be considered a private/self-pay patient and will be responsible for payment at the time of service, as well as any remaining balances billed to you after services are rendered.

Co-payments and Balances After Insurance: Insurance co-payments are due at the time of the visit. Any balances related to deductibles and/or co-insurance must also be paid.

Outside Laboratory: Services sent to an outside laboratory are billed by the laboratory, not DMC. You will receive a separate invoice from the laboratory.

Payment for Services: Payment to DMC may be made in the form of cash, check, or debit/credit card. If you receive payment directly from your health insurance carrier, you agree to endorse or forward payment to DMC for services provided to you by DMC.

Patient Credits: Any patient credits will be applied to other outstanding patient balances owed for any other DMC or Derry Imaging Center services received, prior to any refund being issued.

Assignment of Insurance or Health Plan Benefits: You agree to assign and authorize direct payment to DMC for all insurance and health plan benefits and settlements, whether medical or liability insurance (including but not limited to, the proceeds of any settlement or judgement of any third-party claims) as payment for any and all services performed at DMC.

Assignment of Medicare Benefits: You certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. You request the payment of authorized benefits be made on your behalf to DMC and its healthcare professionals rendering care and/or treatment to you, and authorize DMC to submit claims to Medicare for payment, if applicable. You authorize DMC to release to Medicare and its agents any information needed to determine these benefits for related services.

Filing of Third-Party Claims: Upon proof of coverage, DMC will submit a claim for payment of insurance benefits and accept payment from third party payors to be credited to your account, as they are received. The filing of insurance claims by DMC is performed as a service and in no way relieves you of the obligation to pay in full.

Authorization to Release Information: You authorize DMC to release your health information to insurers, governmental agencies or any other entity financially responsible for your medical care, in order to substantiate payment for such medical services, or as required for pre-certification, authorization, or referral to other medical provider(s).

Consent to receive text and email notifications: You consent to receiving electronic notifications regarding your balances and financial responsibilities via text message and email. You may opt out of receiving electronic notifications at any time.

Discharge: Ongoing failure to meet your financial obligations to DMC may result in your discharge as a patient.

I confirm that I have read, understand, and accept the terms of this document and that I am the patient or the patient's legal representative, duly authorized to accept the terms and execute this document.

_____	_____	_____
Signature of Patient/Legal Representative	Printed Name/Relationship to Patient	Date

PATIENT CODE OF CONDUCT

Patient Name (First and Last): _____ Date of Birth: _____

DMC Primary Care (DMC) is committed to providing quality primary care in a safe, respectful, and inclusive environment. In return, we expect our patients to speak and behave in a respectful manner. If an issue should arise, there are protocols in place to express dissatisfaction. DMC staff will listen, and whenever possible, work to resolve any concerns.

Words or actions that are disrespectful, racist, discriminatory, hostile, or harassing are not acceptable and could be cause for discharge from our practice.

Examples of unacceptable comments or behaviors include, but are not limited to:

1. Offensive comments about others' race, accent, religion, gender, sexual orientation, or other personal traits
2. Refusal to see a clinician or other staff member based on these personal traits
3. Physical or verbal threats or assaults
4. Possession of a weapon while on the premises
5. Sexual or vulgar words or actions
6. Disrupting another patient's care or experience

This Code of Conduct is in place ensure that DMC provides a positive experience for every patient. **Failure to adhere to these requirements may be cause for discharge from our practices.**

By signing below, I acknowledge the DMC Primary Care Patient Code of Conduct:

_____ _____

Signature of Patient/Legal Representative: Date

_____ _____

Print Name of Legal Representative (if applicable) Relationship to Patient

GENERAL CONSENT FOR TREATMENT

PATIENT NAME (First and Last): _____ Date of Birth: _____

CONSENT FOR TREATMENT: I hereby voluntarily consent to care, treatment, testing, and all other services performed by healthcare providers and other staff members at all DMC Primary Care (DMC) locations. I understand that I have the right to refuse to consent to any proposed care, testing, treatment, or procedure. I also understand that I have the right to ask questions and discuss my concerns with my healthcare provider. I acknowledge that no guarantees have been made to me as to the outcome of my care, examination, and/or treatment at DMC.

ACKNOWLEDGMENT: I understand that I am required to sign this consent annually or whenever DMC deems it necessary. I understand that I may revoke this consent at any time by notifying DMC in writing, but that my revocation of consent will result in me no longer being able to receive care or treatment from DMC. I further understand that if additional testing or invasive procedures are recommended, I may be asked to read and sign additional consent forms.

PATIENT RIGHTS & RESPONSIBILITIES: I acknowledge that my healthcare is a partnership between DMC and me, and I agree to actively participate and to accept my role and responsibilities with regard to my healthcare decisions.

TELEMEDICINE: I understand that telemedicine (the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and applicable state privacy laws.

STUDENT PARTICIPATION: I understand that DMC occasionally participates in the education of students in healthcare. I may decline their participation in my care at any time.

RECORDING: I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. It is also my responsibility to assure those accompanying me also comply with this requirement.

RELEASE OF INFORMATION: I understand that protected health information (PHI) typically includes information about my symptoms and health condition, results of physical examinations and diagnostic tests, plans for future care and treatment, and demographic and photographic identifiers. Such PHI will be used, shared, or disclosed only for the purpose of treatment, payment, and healthcare operations, or as required by law. Otherwise, my PHI will not be disclosed without my authorization, except in certain circumstances, which are outlined in DMC's Notice of Privacy Practices. I understand that the DMC Notice of Privacy Practices is posted in all DMC facilities and is available on the DMC website. I may also request a written copy of the Notice of Privacy Practices at any time.

COMMUNCATION: I consent to provide my telephone number(s) so that representatives from DMC may contact me in any manner (manually placing a call, using an automatic telephone dialing system or an artificial or prerecorded voice, or texting), regarding any matter, including my medical treatment, prescriptions, insurance eligibility and coverage, scheduling, billing or collection matters. I understand that I can change my preference at any time.

PERSONAL BELONGINGS: I understand that DMC takes steps to ensure that the waiting room and other areas of the practice are safeguarded. However, I acknowledge that I am solely responsible for any personal belongings that I bring with me to my appointment, including jewelry and other valuables.

_____ _____

Signature of Patient/Legal Representative Date

_____ _____

Print Name of Legal Representative (if applicable) Relationship to Patient

NEW PATIENT MEDICAL RECORDS ACKNOWLEDGMENT AND CONSENT

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Appointment Date: _____ Provider: _____

Thank you for choosing DMC Primary Care. In order to provide a smooth transition into our practice, we ask that you provide us with copies of your previous medical records. Please review the information below to ensure we receive only the necessary records, in a timely and efficient manner.

Patient Responsibilities:

Medical Records Submission

- I am responsible for ensuring that my medical records are received by DMC Primary Care Health Information Management (HIM) Department at least one (1) week prior to my scheduled appointment.
- **I will request the following from my previous provider: a 3-year abstract (which includes office visits, labs, imaging, testing, hospitalizations, specialist visits and procedures), plus all preventative care reports, such as mammograms, colonoscopies, and pap smears.**
- I understand that DMC Primary Care will not accept records beyond three (3) years.

Medical Records Drop-Off & Pick-Up

If I drop off medical records at the location of my appointment:

- I will drop them off at least one (1) week before my appointment.
- Once I am notified that DMC has uploaded my records, I will pick up the original records and/or USB.
- I will sign the Drop off/Pick up form at the time of drop-off and/or pick-up.
- This signed form will remain with DMC Primary Care; however, I may request a copy.

Historical Records / Need for Earlier Appointment

- All medical records received before my initial visit with my provider will be considered historical records.
- Regardless of when I provide my records to DMC Primary Care, they will NOT be reviewed until just prior to my appointment.
- **Therefore, if I have been discharged from a hospital, treated in an Emergency Department and/or in need of a follow-up appointment, DMC Primary Care will not be aware. It is my responsibility to contact DMC Primary Care directly at (603) 537-1300 to request an earlier appointment.**

By signing below, I acknowledge that I have read, understand, and agree to the terms outlined above.

_____ _____

Signature of Patient/Legal Representative: Date

_____ _____

Print Name of Legal Representative (if applicable) Relationship to Patient

COMMUNICATION PREFERENCES AND CONSENT

Patient Name: _____ Date of Birth: _____

In order to provide you with medical information and updates in a timely manner, please provide us with your preferences regarding how we may share your information.

Preferred Method of Communication:

☐ FollowMyHealth Portal (to create a FollowMyHealth account, please go to the "FMH Patient Portal" tab on the DMC Primary Care website)

☐ Phone call (provide current phone number): _____

Do we have your permission to leave a detailed voicemail message containing clinical information?

☐ Yes ☐ No

Consent for Verbal Communication:

The HIPAA privacy regulations allow us to verbally disclose a patient's health information to a family member, friend, or other person, if the patient agrees. Please list any individual(s) that you authorize DMC Primary care to verbally disclose certain components of your health information.

1. Authorized Representative's Name: _____

Phone Number: _____ Relationship to the patient: _____

2. Authorized Representative's Name: _____

Phone Number: _____ Relationship to the patient: _____

DMC Primary Care may release the following information to the Authorized Representative:

☐ Verify the date and time of my appointments

☐ Discuss clinical information (such as test results, imaging results or medication information)

☐ Discuss information regarding my bill or make a payment on my behalf

I understand that I may revise or revoke this Consent at any time by notifying DMC Primary Care, but if I do, it will not have any effect on actions taken by DMC Primary Care before it received the updated information.

_____ _____

Patient Signature Date

_____

Relationship to patient (if not the patient)

DMC Primary Care
ATTN: Health Information
14B Tsienneto Road
Derry, NH 03038

Phone: (603) 537-1300
Fax: (603) 537-1355

UPLOAD RECORDS SECURELY ON WEBSITE:
www.dmcprimarycare.com
UNDER "FORMS"

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

Patient Name/Date of Birth: _____ /_____

Address: _____

I hereby authorize DMC Primary Care to: ☐ RELEASE TO ☐ RECEIVE FROM (please check one):

Person or Facility: _____

Address: _____

Fax: _____ Phone: _____

INFORMATION TO BE DISCLOSED:

☐ **3-year abstract of my records (includes office visits, labs, imaging, testing, hospitalizations, specialist visits and procedures, plus all preventative care reports, such as mammograms, colonoscopies, and pap smears**)

☐ Immunizations ☐ Most recent physical exam

Date range: _____ ☐ Labs ☐ Imaging ☐ Office visits ☐ Other: _____

IF YOU ARE A NEW PATIENT, PLEASE DO NOT PROVIDE US WITH ANY RECORDS BEYOND THE LAST 3 YEARS

*****IMPORTANT – PLEASE READ PARAGRAPH BELOW*****
By checking the box and signing my initials next to a category of highly confidential information listed below, **I DO NOT** authorize the use and/or disclosure of the type of highly confidential information indicated next to my initials, otherwise, the information listed below may be sent/obtained as requested.

I DO NOT AUTHORIZE THE RELEASE OF:

☐ Mental Health/Behavioral Health Treatment _____
☐ Sexually Transmitted Infections _____
☐ Genetic Testing _____
☐ HIV/AIDS Testing or Treatment _____
☐ Substance Use (alcohol/drug) _____

PURPOSE OF REQUEST: ☐ Personal ☐ Medical Care ☐ Legal ☐ Insurance ☐ Workers' Compensation
☐ Disability Determination ☐ Other: _____
☐ Transfer out of practice (reason): _____

By signing below, I acknowledge the following: ○ DMC Primary Care will treat me even if I decline to sign this authorization. My treatment, payment, enrollment or eligibility for benefits may not be conditioned upon signing this authorization. ○ I may inspect or obtain a copy of this authorization and/or the protected health information described in this authorization. ○ Information disclosed under this authorization may be re-disclosed by the recipient, and this re-disclosure may no longer be protected by federal or state laws. ○ I may revoke this authorization at any time by submitting a request in writing to DMC Primary Care, Health Information Management. This revocation will not apply to any previously released information. ○ Fees may apply to requests from third parties, as permitted by federal regulations. ○ This authorization expires one year from the date of signature.

_____ _____
Signature of Patient or Legal Representative/Guardian Relationship to Patient

_____ _____
Printed Name Date

DMC PRIMARY CARE

PREVENTIVE HEALTH VISITS AND ADDITIONAL MEDICAL SERVICES

Patient Name (First and Last) _____ Date of Birth_____

Annual physical exams and Medicare Wellness Visits (AWV) are considered **preventive** health visits. During a preventive health visit, your healthcare team will talk with you about your medical history, your current health, and your risk for certain illnesses and injuries. Most health insurances cover a preventive health office visit at 100%.

However, during the course of your preventive care visit, your provider may discover or need to investigate and treat a new problem, or an existing problem that has changed. You may also bring up a new medical concern to your provider during a preventive visit to be addressed. This additional care is considered **diagnostic**, meaning your provider is treating you because of certain symptoms or risk factors, and becomes separate from your preventive care visit. When this occurs during an annual physical exam or wellness visit, you may receive additional charges. You will be billed for any unpaid balance for your visit after payment has been received from your insurance company, (for example: copays, deductibles, coinsurance).

It is important that you understand your health insurance benefits, and we strongly encourage you to contact your health insurance plan if you have any questions about what is covered under a preventive health visit.

Your signature acknowledges that you were provided this information prior to your preventive visit.

Signature (Patient or Parent or Guardian): _____ Date: _____

Print name (Parent or Guardian) _____

For office use:
Witness printed name: _____ Signature: _____ Date: _____