James M. Gill, MD, MPH

Family Medicine
AT GREENHILL
Caring for Infants to Seniors

Welcome to Family Medicine at Greenhill!

We would like to take this opportunity to introduce ourselves.

Our practice provides high-quality primary health care services for children and families, couples and single individuals without regard to race, gender identity or income level. We provide, for all of your health care needs, Telemedicine Visits, Home Visits and Comprehensive Women's Health Services. We participate with Medicare as well as most insurance plans, please check our website.

We currently see patients in two locations for your convenience:

Greenhill Avneue location
Family Medicine at Greenhill
213 Greenhill Avenue
Suite B
Wilmington, DE 19805
Office hours:
Monday - Thursday
7:00 a.m. - 7:00 p.m.
Fridays 7:00 a.m. – 5:00 p.m.
Walk in hours (Greenhill location only)
Monday through Friday 4:00 p.m.-5:00 p.m.
Saturdays **(by appointment only at our Greenhill location)**
8:00 a.m. – 1:00 p.m.

Limestone Road Location
Family Medicine at Greenhill
1941 Limestone Road
Suite 210
Wilmington, DE 19808
Office hours:
Monday through Friday
8:00 a.m – 5:00 p.m.
NO WALK IN HOURS AT THIS LOCATION

Enclosed, you will find our new patient information forms to be completed to the best of your knowledge. Patients or parents **signature is required** on each page where indicated. The packet can be returned to our Greenhill Avenue location via fax to 302-429-9284, email to office@fmagreenhill.com, drop-off in person or U.S. mail **to Family Medicine at Greenhill, 213 Greenhill, Suite B, Wilmington, DE 19805**. Once your paperwork is received, we will review your information and someone from our office will contact you.

Thank you for choosing Family Medicine at Greenhill, we look forward to meeting you!

213 Greenhill Ave Suite B Wilmington, DE 19805
1941 Limestone Road Suite 210 Wilmington, DE 19808

302-429-5870
Fax 302-429-9284
office@fmagreenhill.com
www.fmagreenhill.com

Family Medicine at Greenhill

213 Greenhill Avenue, Suite B, Wilmington, DE 19805 Phone (302) 429-5870 Fax (302) 429-9284

New Patient Information

Name: _____ _____ _____
(last) (first) (middle)

Date of Birth: _____/_____/_____ Marital Status: S M D W Sex: M F

Social Security #: _____-_____-_____ Email: _____

Address:

_____

_____
(city) (state) (zip code)

Home Phone #:(_____)_____ Cell Phone #:(_____)_____ Work Phone #:(_____)_____

Emergency contact name: _____ Relationship to Emergency Contact _____

Emergency contact phone number: _____Physician you are requesting: _____

OK to leave messages on my answering machines/voice mail? Y N Ok to leave messages with another person? Y N

As required by the health Information Portability and Accountability Act (HIPAA) you have a right to request that communications concerning your personal health information be made through confidential channels.

The best way to reach you is [ ] Cell[ ] Patient Portal (email)[ ] Home [ ] Work

Is this visit due to an auto accident or work-related injury? Y N

Referring Physician: _____ Phone #: _____

Preferred Language: [ ] English [ ] Spanish [ ] Other:

Race (Check all that apply): [ ] White [ ] Black/African American [ ] Hispanic/Latino [ ] American Indian/Alaskan Native

[ ] Asian [ ] Pacific Islander/Native Hawaiian [ ] Prefer not to answer

Ethnicity: [ ] Hispanic or Latino [ ] Non-Hispanic or Latino [ ] Prefer not to answer

Acknowledgement of receipt of the HIPAA Notice of Privacy Practices

I acknowledge that I have read and understand the HIPAA Notice of Privacy Practices.

Signature: _____ Print Name: _____ Date: _____/_____/_____

For Minors

Name of Parent/Guardian for patients under 18 years:_____ Phone #: _____

Pharmacy Information

Pharmacy Name: _____ Pharmacy Phone #: _____

Location: _____ [ ] Retail [ ] Mail Order

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Previous Primary Care Physician

Physician Name: _____ Physician Phone #: _____

Physician Office Address: _____
Address City State Zip

Billing Information

Person responsible for paying bills: _____

Address if different than patient: _____
Address City State Zip

It is the responsibility of the patient to confirm with our office that we take your insurance, have you confirmed with our Office that we take your current Insurance? [ ] Yes [ ] No

Primary Insurance: _____

Claim Mailing Address: _____
Address City State Zip

Subscriber name: _____ Patient relationship to subscriber: _____

Subscriber Social Security #: _____ Date of Birth: _____

Insurance ID #: _____ Plan/Group #: _____

Secondary Insurance: _____

Claim Mailing Address: _____
Address City State Zip

Subscriber name: _____ Patient relationship to subscriber: _____

Subscriber Social Security #: _____ Date of Birth: _____

Insurance ID #: _____ Plan/Group #: _____

It is the patient's responsibility to pay deductibles, co-insurance.co-pays on the day of service, and to pay any other balance not paid for by insurance. If we are filing your claim, we will allow forty-five days from the filing date for the carrier to process your claims and make payment. If an insurance payment is not received within this time frame, we will notify you to clear your account. Insurance filing is done as a courtesy to you and does not dismiss your responsibility to pay for services. Self-pay patients must pay for services the day on which they are rendered.

I understand that I am financially responsible for all charges incurred whether or not paid by an insurance carrier.
I hereby authorize said assignee to release all information necessary to secure payment. This assignment applies to all charges outstanding as the date of signature and will remain in effect for all current and future charges until revoked in writing. A photocopy of this assignment is to be considered as valid as the original. Should the account be referred to an attorney for collection the undersigned shall pay reasonable attorney's fees & collection expense.

Signature: _____ Date: _____

Parent (if minor): _____ Date: _____

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New Patient Medical History - ***Please complete this two-sided form prior to our first appointment***

Name: _____ Date of Birth: ____/_____/____ Age: _____ Sex: _____
How did you hear about our practice?

♦ Social Educational and Work History ♦		
Marital Status: M S D W	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Highest Level of Education:	Completed at which institution / school:	
What type o exercises do you perform, duration and frequency?		
In what type of residence do you live (i.e., house, assisted living nursing home)?		
What are our hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
Are you sexually active: Yes No	Do you have sex with? Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		
On average, how much did you smoke per day?		

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	Reaction	Medication / Food	Reaction

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	Strength	Number of Pills taken & frequency	Medication	Strength	Number of pills taken & frequency
Example: Tylenol	500 m	1 - twice daily			

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of our vaccines and health screening tests

	Month / Yr.		Month / Yr.		Month / Yr.
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pa Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurism Screen	
Gardasil Vaccine		Chest X-Ra		HIV Test	

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♦ Review of Systems ♦

*Please review the following symptoms and **circle** those items that are a problem for you*

Vision problems	Wheezing	Lum s in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Ha fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in le s	Seizures / Tremor
Lum s in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	Hi h blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / pain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficult sleeping

♦ Past Medical History ♦

Condition / Disease	Year Began	Condition / Disease	Year Began
○ Hypertension		Other(s):	
○ High Cholesterol			
○ Hypothyroidism (low thyroid)			
○ COPD, Emphysema or Asthma			
○ Diabetes			
○ GERD			
○ Depression or Anxiety			
○ Heart Problems			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	*Month/ Yr.*	*Operation / Hospitalization /Injury*	*Month / Yr.*

♦ Other Physicians and Specialists ♦

List below our other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc.)

Physician Name	***Special***	***Date o Last Visit***

♦Family Health History♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	Living or Deceased	Current age or age at death	Cause of Death	Health Problems
Father:				
Mother:				
Brother(s):				
Sister(s):				

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Family Medicine at Greenhill Office Financial Policy

Thank you for choosing Family Medicine at Greenhill (FMAG) as your healthcare provider. FMAG is committed to your care. Please understand that payment of your bill is considered a part of your care. We require you to read and sign this statement prior to seeing your health care provider.

How may I pay? Payments can be made by cash, money order, check, debit or credit card. A returned check fee in the amount of $35.00 may be assessed to your account for every check returned for insufficient funds, stopped payment or a closed account.

What is my responsibility for my insurance plan's requirements? Our staff interacts with many insurance companies, each with different rules and regulations. Although we will do our best to assist with your insurance company's requirements, it is the patient's responsibility to ensure that all required permissions are obtained including referral, pre-certification, pre-authorization and using in-network facilities. You will be responsible for the entire bill if payment is denied by the insurance company for failure to obtain the requirements.

Insurance and Personal Information: It is the patient's responsibility to ensure we have the most current and updated information possible. You must bring your current insurance card with you to each visit and notify us of any changes in address, phone number or marital status.

Co-payments: FMAG is contracted with most insurance providers and is contractually required to collect ALL co-pays prior to service. Please be prepared to pay the co-pay at each visit.

Self-pay (Cash/Credit Card): Patients If you do not have health insurance, payment in full is expected at the time of service. If services are paid in full at the time of service, FMAG will extend a 20% discount.

Minors and Dependents: Parents are financially responsible for care rendered to their minor child(ren). As many insurance companies cover adult child(ren) who are full-time students, it will be the parents' responsibility for any balance on the account. I further understand that both biological parents have access to full disclosure (even if not the custodial parent) and both can authorize representatives unless parental rights have been terminated by court order. I understand if there are Custody Orders in place, I must present current copies for my child's file. I authorize the people listed to bring my child to any appointments in my absence and Family Medicine at Greenhill may call and leave a message regarding my child's clinical care, including lab and x-ray results in my absence. I understand this authorization for release of information will remain in effect until parent or guardian changes their disclosure with Family Medicine at Greenhill in writing. At that time this authorization will expire. I authorize Family Medicine at Greenhill, only upon my request, to fax any forms or immunization records to my child's school. I authorize Family Medicine at Greenhill to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers, my health insurance, my attorney, and/or other health practitioners. I authorize my insurance plan to make direct payment of medical benefits, to include major medical benefits, to Family Medicine at Greenhill.

Motor Vehicle Accidents: We are pleased to see patients for Motor Vehicle Accidents however, to meet legal requirements, we must have full insurance details, claim number and claim address so that we can process authorization before the time of your visit. If these are not available, then your visit may be regarded as a self-pay appointment. We cannot bill private medical insurance for these claims since they are generally not covered. **We do not accept Workers' Compensation cases**.

Form Completion We will complete forms submitted to our practice during a scheduled office visit ONLY.

Missed Appointments: We require at least 24 hours' notice for cancellation of appointments. New patient appointments that are not canceled with required 24-hour notice will be counted as a No Show. New Patients who No Show for the first appointment **will not** be rescheduled. For established patients we have a three-strike policy and patients who repeatedly miss appointments may be asked to find another provider.

Medicare: Our physicians have agreed to accept assignment on all Medicare claims. Accepting assignment means that we must accept Medicare's approved amounts. However, you should know that Medicare only pays a portion (generally 80%) of the approved amount above your deductible. In addition to your deductible, you are responsible for the other portion (generally 20%) of the approved amount unless you have a supplemental plan that covers these fees. You will be billed for any allowable balance not covered by Medicare and/or your supplemental insurance plan.

Signed: _____ Print Name: _____ Date: _____

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Patient Consent Form

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.
I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I the undersigned authorized FAMILY MEDICINE AT GREENHILL to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to FAMILY MEDICINE AT GREENHILL.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) Signature Date

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PHI Use and Disclosure Authorization

This form authorizes the use or disclosure of protected health information in the manner described below and is voluntary. Family Medicine at Greenhill will still provide medical treatment if you do not sign this authorization, except under limited circumstances that are described in our Notice of Privacy Practices. Please be aware that once your information leaves Family Medicine at Greenhill, Family Medicine at Greenhill will no longer be able to protect that information, and the recipients of your information may not be legally required to protect your information.

Name of patient: _____ _____ _____

Last Name First Name Middle Name

DOB: _____/_____/_____ Address: _____

_____

I authorize Family Medicine at Greenhill to use and disclose the following protected health information:

_____

_____

Purpose of Disclosure: At request of patient Continuing Care Personal Records Legal Insurance Other

Name of Persons or Entity to Receive Information:

_____ _____ _____

Name Relationship Phone #

_____ _____ _____

Name Relationship Phone #

Release of the following information requires specific authorization. Initial by those that apply:

_____ HIV/AID testing/Treatment Records

_____ Drug, Alcohol or Substance Abuse Records

_____ Mental Health Records (excludes psychotherapy)

_____ Genetic Markers

I understand that I have the right to terminate or revoke this authorization at any time. To do so, my request must be provided to your office in writing. Written requests can be sent to Cheryl Mongillo, Privacy Officer, Family Medicine at Greenhill, 213 Greenhill Avenue, Suite B, Wilmington DE 19805. I understand that revocation is not effective if my authorization was obtained as a condition of obtaining insurance coverage.

I understand that this authorization is effective 12 months from signature date unless a different expiration date is provided _____/_____/_____ (specify new date)

I understand that information that is disclosed under this authorization may be disclosed under this authorization may be disclosed by the recipient, as such the privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to. I understand that my authorization is not required as a condition to receive treatment, payment, or enrollment or eligibility for benefits.

Name of patient or Personal Representative (Type/Print)

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Description of Personal Representative's Authority Date

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Medical Records Transfer Request Form

I, _____ (patient) hereby authorize and request that you transfer a copy of all records in your possession concerning any diagnosis, prognosis and recommendation, as well as other data pertinent to your treatment of the patient named below.

Patient Information

Patient Full Name:	
Patient Address:	Date of Birth:
City:	Phone:
State: Zip:	
From (name of practice):	**To: Family Medicine at Greenhill** **Attention:**
Practice Address:	213 Greenhill Avenue
City:	Wilmington
State: Zip:	DE 19805
Office Phone number: _____ Office Fax number: _____	Office Phone: 302-429-5870 Office Fax: 302-429-9284

_____ _____

Patient Signature Date