Delaware Clinical & Laboratory Physicians

Providing pathology, hematology, and blood and marrow transplantation services to our community

Frank V. Beardell, M.D., Scott W. Hall, M.D., Michael W. Lankiewicz, M.D., Jenny Petkova, M.D., R. Bradley Slease, M.D., Peter Abdelmessieh, D.C
Phone: (302) 737-7700 Fax: (302) 737-5407 Helen F. Graham Cancer Center 4701 Ogletown-Stanton Road Suite 4200 Newark, DE 19713

Please call 2 days prior to
Confirm your appointment

Dear Patient,

Welcome to the hematology office of doctors Peter Abdelmessieh, D.O., Frank V. Beardell, M.D. Scott W. Hall, M.D., Michael W Lankiewicz, M.D., Jenny Petkova, M.D. R. Bradley Slease MD. This letter will help answer questions about your upcoming appointment.

Your appointment date and time are on the accompany letter attached, along with a lap slip.

The Day of Your Visit:

Enclosed you have a lab slip with tests you need to have completed prior to the appointment. If your insurance allows you to get the bloodwork at Christiana Care Health System, the lab test should be done 30 minutes prior to your scheduled appointment time. The lab is located on the 2nd floor (room 2340) at the West entrance of the Cancer Center. Note that there are no special eating instructions for your lab work. Once your laboratory services are complete, proceed to our office on the 4t floor of the Cancer Center (suite 4200).

If your insurance is not participating with CCHS lab or you are not sure that you can get your blood work done at Christiana Care lab, please call and ask. The phone number for the lab is 302-623-4640. If you cannot use CCHS lab, you should use the preferred lab directed by your insurance company 1 week prior to your scheduled visit with us (DCLP).Please complete enclosed forms

- Bring photo I.D., insurance cards, and payment for copay due at time of service (cash, check or credit card)
- Please obtain a referral from PCP if required by your insurance

The providers and staff at DCLP feel that we can better serve your healthcare needs if you are familiar with the following policies and procedures of the group.

Office Hours:

DCLP is open Monday through Friday from 8:00 am to 4:30 pm. Providers are available on an emergency basis at any time.

Appointments:

Appointments may be made by calling (302) 737-7700 during our office hours. Every effort will be made to provide the earliest

possible appointment for the convenience of the patient. Due to the unscheduled nature of emergencies imposed upon the providers, occasional delays do occur.

We hope that you will understand that these delays are unavoidable. If you are unable to keep your appointment, please cancel as far in advance as possible. Some other patient who can be booked into the open time will be grateful for your thoughtfulness.

Sincerely,

The Patient Access Team
Christiana Care Campus
Helen. F. Graham Cancer Center
West Side Entrance 4th Floor, Room 4200

DCLP complies with applicable Federal civil right laws and does not discriminate on the basis of race, color, national origin, age disability, or sex. DCLP does not excluded people or treat them differently because of race, color, national origin , age , disability, or sex.

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Financial Policy Agreement

We will submit an insurance claim for services to your insurance company as a courtesy. A health insurance claim form maybe provided upon request. Payment for all out of pocket expenses not covered by your insurance company is required at time of service. Copayments, Deductibles and Coinsurance or non-covered charges from your insurance company are patient responsibility. We accept cash, check or credit card.

In the event that timely payment cannot be made, special arrangements may be made by calling our Billing Department at (302) 454-9830.

DCLP cannot accept responsibility for collecting your claim or negotiating a settlement on a disputed claim since we are not a party. It must be understood, however, that financial responsibility for the account rests with the patient.

After 90 days, if no payments have been received and no extended payment arrangements have been made, necessary collection proceedings will begin. It is important that you notify us of any changes of address promptly since undeliverable statements are turned over to collection agencies immediately.

I have read and understand the practices financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

Please print name of patient _____

Delaware Clinical & Laboratory Physicians

Communication Form

Hematology
Transfusion Medicine

Jenny Petkova, M.D.

Scott W. Hall, M.D.

Michael W. Lankiewicz, M.D.

R. Bradley Slease, M.D.

Frank V. Beardell, M.D.

Peter Abdelmessieh, D.O.

Pathology

Cynthia E. Flynn, M.D.

Randi LaPoint, M.D.

Michael D. Kanzer, M.D.

William M. Kirby, M.D.

Eric R. Montgomery, M.D.

Gary B. Witkin, M.D.

Phoebe Holmes, M.D.

Steven Kramer, M.D.

Mary Iacocca, M.D.

Proudly Serving Delaware Since 1969

Phone: (302) 737-7700
Fax: (302) 737-5407

Helen F. Graham Cancer Center
Suite 4200
4701 Ogletown-Stanton Road
Newark, DE 19713

www.dclpde.com

Patient Name (Please Print) _____ Date of Birth _____

I hereby request Delaware Clinical & Laboratory Physicians, P.A. to communicate my health information to me via alternative methods. I understand that communication of my health information other than in person increases the risk of my private information to be obtained by others.

Email Address of Patient/Authorized user
(Please Print) _____

Patient Portal: My Care Plus

My Care Plus, the patient Portal offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so. Because personal identifying information and other information about your health and medical history is available via the portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others. If you choose to submit this form, you understand you are consenting to us to email you a unique link that you will use to create a password in order to access the Portal. **PLEASE LOOK FOR AN EMAIL FROM MY CARE PLUS PROMPLTY AFTER SUBMITTING THIS FORM.** For your protection, the link is designed to expire quickly if not used. If you should change your email address, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.
If you wish to discontinue utilizing the Portal, please contact your physician's office. You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form.

Third Party Application

Are you interested in a new option to use an application to view the same information that is available via My Care Plus? This is a new Medicare requirement. DCLP will supply a web site and access code to register for an approved application to access your medical record. You must use the same email on this form and ask for an access code that is only available from the practice.

Yes No

Patient Signature/Authorized User _____ Date_____

Patient's Designee's Name (Please Print) _____

Patients Designee's Signature _____ Date_____

Authorized Facility Signature _____ Date_____

Internal use only identity of patient confirmed ☐	Email entered in Nextgen ☐
confirm information ☐	consent to scan ☐

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NEW PATIENT MEDICAL HISTORY

Name	Date of Birth	Today's Date

Please circle if it applies to you.

Preventive Care

Do you use tobacco? (Circle)
Never Smoker | Former Smoker | Second hand smoke exposure | Current smoker how many cigarettes per day? _____

Currently uses other tobacco (*ie. cigar, chew*) yes no

Have you had a flu vaccine this year? yes no

When was your last colonoscopy? Month/Year _____ Never

When was your last mammogram? Month/Year _____ Does not apply

Past Medical History

Have you ever had? (Circle all that apply)

Asthma | High Blood Pressure | Diabetes
Hepatitis | Heart attack | Radiation
Kidney Disease | Ulcers | Stroke

Surgery?

	Date		Date		Date
No surgical history	_____	Gallbladder	_____	Hernia	_____
Appendix	_____	Heart	_____	Teeth	_____
D&C	_____	Hemorrhoids	_____	Tonsils	_____
Hysterectomy/Partial/Ovaries	_____			Other _____	_____

Hospitalizations? (other than surgery and childbirth)

# of times admitted 0 1 2 3 4 5 over 5 Reason for admission_____

Prior blood transfusion? yes no unknown

Family History (Mother/Father/Brother/Sister)

Does your family have?

	Mother	Father	Brother #1	Sister #1	Brother #2	Sister #2	
Age now							
Age when passed away							
Cause of death							
Cancer (type)							
Heart disease							
Blood Pressure							
Diabetes							
Kidney disease							
Sickle cell							
Thalassemia							
Bleeding disorder							
Clotting disorder							
Other							

Name	Date of Birth	Today's Date

Personal/Social History

Education? (circle)	Some High School	High School	College	Advanced Degree
Marital Status?	Married	Single	Separated	
	Divorced	Widowed	Partnered	
Religion? _____				
Occupation? _____				
Work Status?	Working	Retired	Not working	Disabled
Alcohol Use?	Yes	No	Average # drinks per week? ____	
Drugs of Abuse?	None	Marijuana	Opiates	Cocaine
	Other _____			
Do you have a support system available?		Local family	Distant family	None
Who is your family or primary care doctor? _____				
List other doctors _____				

Review of Systems

Is your general health & energy level? (circle)	Excellent	Good	Fair	Poor
Weight?	Loss	Gain	Same	
Do you have?	Night sweats	Fever	Appetite problems	
	chills	change in vision	Cataracts	Glaucoma
	sinus problems	headaches	dental problems	dentures
	Painful/stiff neck	trouble swallowing	thyroid problems	sore throat
	ear problems	sore mouth		
Do you have heart issues such as?	Murmurs	Angina	Rapid Heart	Chest pain
	Palpitations	Fainting	Swelling of arms & legs	No issues
Do you have breathing issues such as?	Shortness of Breath	Bronchitis	Chronic Cough	Asthma
	Wheezing	Pain when breathing	No issues	
Do you have stomach issues such as?	Pain or cramping	Indigestion	Vomiting	Nausea
	Heartburn	Colitis	Gallstones	Bleeding
	Liver problems	Diarrhea	Constipation	Hemorrhoids
	No issues			

Name	Date of Birth	Today's Date

Review of Systems (continuation)

Do you have kidney issues such as?

Kidney Stones	Prostate Problems	Blood in urine
Infections	Frequent Urination	Wake up to Urinate 1 2 3 4 More
Bladder Infections	Slow Stream	No Issues

Do you have menstrual problems such as?

Does not apply	Heavy/prolonged flow	Severe cramps
No issues	Irregular	
First Day of last menses ____/____/_____		Age at Menopause _____
# of Pregnancies____	Complications Yes No	
# of Deliveries _____		

Do you have? (musculoskeletal, skin, neurological)

Arthritis	Pain/Stiffness	Rash
Hair loss	Skin lumps/bumps	Epilepsy
Confusion	Seizures	Tremors
Brief weakness of hand or legs		Eczema
Depression	Anxiety	Difficulty concentrating

Do you have? (hematologic)

Anemia (ever)	Bleed easily	Gums bleed
Easy bruising	Family blood problems	Nose bleeds

Do you have allergies? No known medication allergies

Medication Name	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other Allergies	Reaction
_____	_____
_____	_____
_____	_____

DELAWARE CLINICAL & LABORATORY PHYSICIANS, P.A.

Patient Information Sheet

Please Print

Patient's Name First Middle Last			
Date of Birth	Sex M F	Race	Marital Status
Address			
City		State	Zip
Social Security	Home Phone		Alternate # for Results & Appointments
Cell Phone Number	Work Phone Number		May we call you at work? Y N
Spouse's Name	Spouse's Work Number		Religion
Physician who referred you to this office?			
Have you ever been treated by any of our physicians? Y N If Yes, Which Doctor?			
Name and location of pharmacy		pharmacy phone number	
Do you have a Living Will? Y N			
Does someone have Power of Attorney for you? Y N If Yes, Name of Person			

Emergency Information

Person to contact in case of Emergency (other than spouse)		
Relationship	Home Phone number	Alternate phone

Employment Information

Patient's Employer (father's if minor)	Phone Number
Address	
Spouse's Employer (mother's if minor)	Phone Number

Insurance Information

Primary Insurance Company Name		Phone Number
Address		
Name of Insured	Relationship to Patient	Date of Birth of Insured
Policy I.D. Number	Insured's Social Security Number	Policy Group Number
Secondary Insurance Company Name		Phone Number
Address		
Name of Insured	Relationship to Patient	Date of Birth of Insured
Policy I.D. Number	Insured's Social Security Number	Policy Group Number
If your insurance Company 's require authorizations it is your responsibility to contact the primary care provider for the referral.		

Signature on File

Medicare

Beneficiary Name:_____ Medicare Insurance claim number: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Delaware Clinical & Laboratory Physicians, P.A. for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related service.

Signature: _____ Date: _____

All Other Insurance

I authorize my insurance Benefits to be paid directly to Delaware Clinical & Laboratory Physicians, P.A. I authorize release of medical information to insurance companies in order for payment to be made. I understand that I am financially responsible for any balance due.

Signature: _____ Date: _____

Person Responsible for Bill other than Patient

Name: _____ Phone: _____

Address: _____

Delaware Clinical & Laboratory Physicians, P.A.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Delaware Clinical & Laboratory Physicians, P.A. (DCLP) is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and our privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. We will use and disclose your health information to provide you with medical treatment or services. (Example)

> "It may be necessary to seek consultation regarding your condition from other health care providers associated with DCLP"

> "It is our policy to provide a substitute health care provider, employed by DCLP, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacations, sickness, continuing medical education, or emergency situations."

> "We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of quality of treatment, and to assess the care and outcomes of your treatment."

We may disclose your health care information to other health professionals, healthcare entities outside of our practice, and/or members of your family in order to facilitate your treatment. (Example)

> "Nurses, physicians and other members of our staff may disclose your health information to other health care providers or entities who are/will be participating in your diagnosis and treatment, to pharmacists who are filling your prescriptions and, unless you object, to family members who are helping with your care."

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (Example)

> "As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to DCLP for health care services rendered. If you pay for your health care services personally, as a courtesy we will provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. You must inform DCLP if you wish to exercise your right to restrict disclosure of any services for which you (and not the insurance plan) paid in full. DCLP will document such medical records for "restricted disclosure" and will not release information regarding the service to your insurance company."

The billing statement contains medical information including diagnosis, date of injury or condition, and codes which describe the health care services received."

Business Associates
We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services (for example, to administer claims or provide DCLP with support services). To perform these functions or services, Business Associates will receive, create, maintain, use and/or disclose your health information, but only after they agree in writing to implement appropriate safeguards to protect your information.

Workers Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury, or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration (FDA) problems with products and reactions to medications, and reporting exposure to disease or infection.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding, as required by law or in response to a subpoena or discovery request. However, we will only do so after we have made efforts to inform you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your health information to a law enforcement office for purposes such as identify or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to corners or medical examiners or State Tumor Registry.

Organ and Tissue Donation
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers when (1) the individual identifiers have been removed; or (2) an Institutional Review Board (IRB) or Privacy Board has reviewed the research proposal, established protocols to ensure the privacy of the requested information, and approved the research.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing
We May contact you for marketing purposes as described below: (Example)

> "As a courtesy to our patients, it is our policy to call your daytime and home phone numbers prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message, other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment"

Any other marketing purpose will require your separate marketing release.

Change of Ownership
In the event that Delaware Clinical & Laboratory Physicians, P.A. is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that DCLP is not required to agree to all the restriction you may request.
- You have the right to have your Health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and obtain a copy of your health information. A charge of $15.00 will be assessed to cover our cost of duplicating your records. An electronic copy of your medical record can be emailed, but only if you provide specific, written authorization after being informed of the security risks of such transmission. Payment must be made in advance. DCLP has 30 days to comply with your request and 60 days if it requests an extension.
- You have a right to request to amend your protected health information. Please be advised, however, that DCLP is not required to agree to amend your protected health information. If your request to amend your health information is denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an account of any disclosure of your protected health information made by DCLP.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.
- You have a right to restrict the disclosure of services for which you (and not the insurance plan) paid in full. You must inform DCLP of the requested restriction, DCLP will document your medical record and designate the restricted service(s).
- You have a right to be notified if DCLP (or a Business Associate) discovers a breach of your Protected Health Information (i.e., an unauthorized use or disclosure).

Changes to this Notice of Privacy Practices

DCLP reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make any new provisions effective for all information that DCLP maintains. Until such amendment is made, DCLP is required to comply with this Notice.

DCLP is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Carolmarie G. Mahoney by calling our corporate office at (302) 454-9830. If Carolmarie G. Mahoney is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights or how DCLP has handled your health information should be directed to Carolmarie G. Mahoney by calling our corporate office at (302) 454-9830. If Carolmarie G. Mahoney is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your compliant, you may submit a formal compliant to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington DC 20201

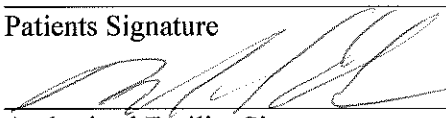
This notice is effective as of 6/1/2013

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Delaware Clinical & Laboratory Physicians, P.A. (DCLP) with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice

_____
Patients Name (print)

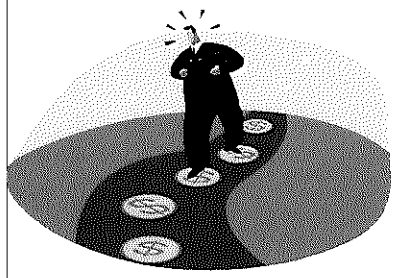
_____ _____
Patients Signature Date



_____ 10/18/18
Authorized Facility Signature Date

About Us

Delaware Clinical & Laboratory Physicians, P.A. is a private practice of Hematologist and Pathologists established in 1969 and located in New Castle County, Delaware. Our physicians, nurses and staff work within a patient centered atmosphere to provide a compassionate environment to treat patients diagnosed with blood disorders, thrombosis and blood cancers.



Delaware Clinical & Laboratory Physicians, P.A.

4701 Ogletown– Stanton Rd

Helen F Graham Cancer Center Suite 4200

Newark, De 19713

Phone: (302) 737-7700

Fax: (302) 737-5407

Delaware Clinical & Laboratory Physicians, P.A.

Financial Policy

Payment Expectations

It is the practice of Delaware Clinical & Laboratory Physicians, P.A. (DCLP) to collect all co-pay, co-insurance, and/or outstanding deductibles up front and in full at time of service. Your are directly responsible for any unpaid balance on your account. If you do not carry insurance, payment in full is expected at the time of your visit.

Recognizing that circumstances may arise where an individual is unable to pay in full at the time of service, DCLP has adopted a policy of allowing patients to make contractual arrangements for payment plans that allow them to pay in monthly installments.

If unforeseen circumstances arise it is possible for a patient to apply for a financial hardship.

If your are having difficulty paying for the coinsurance or copayments for your infused or oral medications please ask to speak with the Patient Financial Services Representative available at the clinical office.

Options

Payment Arrangements

If you are unable to pay your balance in full at the time of service please speak with us about your alternatives

Our payment plan policy requires a minimum of 30% of the balance due as a down payment with monthly payments and amounts based on the balance of your account.

Balances less than $100.00 must be paid within 90 days from the date of service.

Balances between $101.00 and $300.00 must be paid within 120 days from the date of service.

Balances between $301.00 and $500.00 balance paid within 180 days from date of service.

Balances over $500.00 a personalized plan must be approved by the Business Office Manager and/or the Executive Director..

Ask the Patient Financial Services Representative for a Payment Arrangement Contract

Financial Hardship Programs

DCLP will honor patients already participating in local programs.

Delaware Community Healthcare Access Program (CHAP)

Recipients receive discounted medical services based on their income. To contact CHAP call (800) 996-9969

Christiana Care Health System's (CCHS) Charity Care Program

The hospitals financial assistance program contact number (302) 623-7000

DCLP Financial Hardship Program
Our Business Office Manager will review our Financial Hardship Application for possible assistance.

Please ask for a Financial Hardship Application.

Delaware Clinical & Laboratory Physicians, P.A.

Business Office
PO Box 12210
Wilmington, De 19850

Phone: 302-731-8578
Fax: 302-454-1445