Lifespan Family Healthcare, LLC

80 River Road
Newcastle, ME 04553
(207) 563-3366 Fax (207) 563-3393

Office Hours: Monday – Friday 8:00am - 4:30pm
Ask about our extended hours on Wednesdays

Location: Lifespan Family Healthcare is located at 80 River Road in Newcastle, next to the fire station.

Payments & Insurance Billing:
As a courtesy to our patients we will submit insurances claims. Please be aware that some or perhaps all of the services rendered may or may not be covered. If your insurance company denies payment, you will be billed.

We are currently participating in the following:

Anthem Blue Cross/Blue Shield
MedNet / United Healthcare / Harvard Pilgrim
Aetna / Cigna / Maine Community Health Options
Maine Care (not managed care) / Martin's Point
Medicare (currently not taking new patients)

Please bring your insurance card(s) for each visit. Please be aware it is your responsibility to know your co-pay and/or deductible information, along with information on covered services. If your insurance can not be verified, payment in full is due at the time of service. Once your insurance has been verified, we require payment of co-payments as defined by your primary carrier. We accept cash, checks and major credit cards. A minimum of $35.00 fee will be assessed on all returned checks. If you do not have medical insurance, payment is due at time of service. If you need special payment arrangements please contact our office manager, prior to your appointment.

IMPORTANT PLEASE READ Appointment Cancellations/No shows policy: Please give 24 hours notice if an appointment needs to be re-scheduled or canceled, otherwise it will be considered a "no show". **We charge $35 for "No Show" appointments.** Three "no shows" will be grounds for dismissal from the practice. If you "no show" for your initial appointment, your no-show fee will be collected prior to you scheduling your next appointment.

Forms to fill out and return:

- Patient Information
- Health History
- Financial Policy (sign)
- Consent for use of PHI (sign)
- Records Release form (sign)

Form print and keep with your records:

- Notice of Privacy Practices

Intake process: Once you have returned your forms they will be reviewed for acceptance then we will request your medical records. You will be contacted for an appointment once the medical records have been received. If you have an HMO plan you will need to change your PCP to Michael H Clark before your appointment.

We look forward to meeting you and assisting you with your medical needs.
If you have any questions, please give us a call.

Telephone Extension Quick Reference

1 - Office information
2 - Scheduling Medical
3 - Medication refills
4 - Cally - Shane's Medical Assistant
5 - Sandy - Billing / Administration
6 - Kelli - Dr. Clark's Medical Assistant
7 - Mickie – Referrals/Medical Records
0 - Becky - Front Desk/ Counseling Scheduling
112- Rebecca – Medical Assistant

On-call number for after-hours medical questions

207-882-1062

Patient Portal – on our website:

www.lifespanfamilyhealthcare.com

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Patient Information **web17**

Patient Name (Last, First, Middle)			Social Security # _____-_____-_____ Date of Birth ____/____/____
Male__ Female__	Marital Status: S____M____W____D____O____		Name of Spouse:
Physical Address	City & State		Zip Code
Mailing Address	City & State		Zip Code
Preferred method of contact Phone Portal Mail	Email		
Preferred Pharmacy	Home Phone	Work Phone	Cell Phone
	Race	Ethnicity	Language
Occupation	Employer Name	Employer Address	

Insurance Information: Please provide a copy of your insurance card(s)

Insurance Carrier Name:			
Policy Number	Group Number		
Subscriber's Name (who holds the insurance?)	Relation to Patient (circle one) Self Spouse Parent Employer Other		
Subscriber's Social Security #	Subscriber's Street address	City & State	Zip Code
Subscriber's Home Phone ( )	Subscriber's Work Phone ( )	Date of Birth	M ___ F___
Subscriber's Employer	Employer's Street address	City & State	Zip Code
Effective Date	Expiration Date	Is Patient covered by additional Insurance Yes___ No____	
Medicaid Number	Medicare Number	Co-Pay Amount	

Emergency Contact Information

In case of Emergency contact	Relationship to Patient	Emergency Phone Number ( )

If this patient is a minor or student: Please indicate how you would like statements addressed if you do not want them addressed directly to the patient.

Health History Questionnaire

Have *You* ever had:

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Hardening of the arteries or coronary heart disease
- ☐ Heart valve disease
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Diabetes (circle): Type I (juvenile-onset) Type II (adult-onset)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Asthma
- ☐ Hay fever or allergic rhinitis
- ☐ Emphysema
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Stomach ulcers
- ☐ Anxiety or panic attacks
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Other psychiatric disease: _____
- ☐ Alcoholism
- ☐ Stroke
- ☐ Migraine headaches
- ☐ Kidney stones
- ☐ Gout
- ☐ HIV/AIDS
- ☐ Other sexually transmitted infections: _____
- ☐ Hepatitis B or C (circle)
- ☐ Anemia
- ☐ Hemophilia/bleeding disorder
- ☐ Glaucoma
- ☐ Epilepsy/seizures
- ☐ Cancer: Where or What Type(s):_____
- ☐ (Men) Prostate Enlargement

Women:

- ☐ Abnormal pap smear
- ☐ Tubal Pregnancy
- ☐ Diabetes in pregnancy
- ☐ Toxemia/preeclampsia
- ☐ Total # of Pregnancies: _____

# of Births: Term: ___Preterm:___

Miscarriages: ___Abortions: ___

- ☐ Other disease: _____

(Please include approx. date/year)

- ☐ Tonsillectomy_____

Surgeries *You* Have Had:

- ☐ Sinus surgery_____
- ☐ Appendectomy_____
- ☐ Gall bladder removal_____
- ☐ Exploratory surgery_____
- ☐ Cataract removal_____
- ☐ Hysterectomy_____

Were ovaries removed?

(circle) No / Left / Right / Both

- ☐ Mastectomy: _____

(circle) Right / Left

Lumpectomy / Simple / Radical

- ☐ Hernia repair_____

(circle) Right / Left

- ☐ Coronary artery bypass_____
- ☐ Balloon angioplasty_____
- ☐ Pacemaker placement_____
- ☐ Hip Replacement: R L _____
- ☐ Knee Replaced: R L_____
- ☐ Back Surgery_____
- ☐ Tubal Ligation_____
- ☐ Prostate Surgery_____
- ☐ Vasectomy _____
- ☐ Other_____

Family Health History **Adopted: _____**

Family Member	If Living or dead (age of death)	Current Illness / Cause of Death
Mother		
Father		
Brother / Sister (circle)		
Brother / Sister (circle)		
Brother / Sister (circle)		
Brother / Sister (circle)		
Brother / Sister (circle)		

Does a family member HAVE OR HAD check box: (Please circle to indicate Mother Father Sister Brother Grandmother or Grandfather)

- ☐ High blood pressure: *M F S B GM GF*
- ☐ High cholesterol: *M F S B GM GF*
- ☐ Heart attack: *M F S B GM GF*
- ☐ Osteoporosis: *M F S B GM GF*
- ☐ Diabetes (circle): *M F S B GM GF*

Type I (juvenile) or Type II (adult)

- ☐ Cancer: (who and what type):

M _____ *F* _____

S _____ *B* _____

GM _____ *GF* _____

- ☐ Thyroid Problems: *M F S B GM GF*
- ☐ Asthma: *M F S B GM GF*
- ☐ Genetic Disease or "birth defect"

What type:_____ *M F S B GM GF*

- ☐ Rheumatoid Arthritis: *M F S B GM GF*
- ☐ Anxiety panic attacks: *M F S B GM GF*
- ☐ Psychiatric Illness: *M F S B GM GF*
- ☐ Depression: *M F S B GM GF*
- ☐ Alcoholism: *M F S B GM GF*
- ☐ Stroke: *M F S B GM GF*
- ☐ Migraine headaches: *M F S B GM GF*
- ☐ Gout: *M F S B GM GF*
- ☐ Bleeding Disorders: *M F S B GM GF*
- ☐ Epilepsy: *M F S B GM GF*
- ☐ Other : _____

Health History Questionnaire (cont.)

Please list all *Prescription Medications* that you are currently taking: (Print clearly)

Medication Name Strength/Dose Quantity taken Times per day

Please list all *Supplements, Herbals or Over the Counter Remedies* that you currently take:

Name Strength (if known) How often

Please list any *Allergies* to *medications*:

Name of Medication: Type of reaction (e.g. rash, itching, swelling, difficulty breathing, etc)

Please list *Other Sensitivities* and *Allergies* you have experienced:

Name of Allergen Type of reaction Comments

Health/Diet/Lifestyle:

Describe your diet: _____

How often do you exercise? _____

Do you currently use tobacco? _____ How many packs per day _____?
Are you a former tobacco user? _____ Year Quit _____ Smoked _____ packs per day
Never used tobacco _____

What is your daily alcohol intake? _____

Health History Questionnaire (cont.)

Please describe your current living situation:
☐ House or apartment ☐ Staying with friends ☐ Group home ☐ Senior housing
☐ Assisted living ☐ Nursing home ☐ Homeless/ in shelter ☐ Other _____

Who lives with you:
☐ Alone ☐ Spouse ☐ Partner or significant other ☐ Children ☐ Parents or other family members
☐ Roommate(s) ☐ Other _____

Please check any that apply:
☐ Exclusive sexual relationship with spouse or partner ☐ Not currently having sex ☐ Have sex but not always with same person ☐ Heterosexual ☐ Homosexual ☐ Other _____

Do you have a living will? ☐ Yes ☐ No (We encourage patients to provide a copy for our records)

Vaccination status: (Please provide any copies of vaccination records that you have)
If you were born after 1957, have you had a **2nd** measles, mumps and rubella vaccine? ☐Yes ☐No ☐Unsure
If you are at least 65 years old or have a chronic health problem or breathing problems, have you received the **pneumococcal vaccine**? ☐ Yes (date): ____ /____ /____ ☐ No ☐ Unsure
Date of last tetanus booster: ____ /____ /____

Self Care and Prevention
Is your time well balanced between your job, family, self-care and hobbies? ☐ Yes ☐ No
If you are a ***female***, do you do a monthly self-breast exam? ☐ Yes ☐ No
When was your last breast exam by your physician? Date: ____ / ____ / ____
Date of last mammogram: ____ / ____ / ____ ☐ Never had a mammogram
Note: One out of every 10 women will get breast cancer. The best approach is early detection by doing a monthly self-breast exam, an annual breast exam by your physician and periodic mammograms.
Date of last pap smear: ____ / ____ / ____ ☐ Never had a pap smear
Date of last bone mineral density test (DEXA scan): ____ / ____ / ____ ☐ Never had this test

If you are a ***male***, do you do a monthly self-testicular exam? ☐ Yes ☐ No
Note: Testicular cancer is a leading cause of cancer for men under the age of 50.

Spirituality and Faith
Do you consider yourself a spiritual or religious person? ☐ Yes ☐ No
Are you part of a spiritual or religious community or church? ☐ Yes ☐ No
Which faith tradition or denomination do you identify with? _____☐ or None
Do you feel good about or supported by your current spiritual beliefs, practices or level of participation with your church/faith community? ☐ Yes ☐ No

FINANCIAL POLICY

As a courtesy to our patients we file most insurance. Please be aware that some or perhaps all of the services rendered may or may not be covered. If your insurance company denies payment, you will be billed and payment in full is due upon receipt.

We cannot file your insurance unless you have your card with you. Your insurance must be current and verifiable at the time of treatment. Payment assignment must be made to this office. If you wish to have the check sent to you, payment in full is due at the time of service. Co-pays and payment for non-covered items are due at the time of treatment. We charge $35 for "No Show" appointments, to be paid prior to or on your next appointment. We accept cash, checks and major credit cards. Should it be necessary to utilize outside collection means for past due account, you are responsible for all cost, including attorney, court, and collection fees. We will not carry balances for more than 2 years. A minimum $35.00 fee will be assessed on all returned checks.

I have read and understand the Financial Policies of Lifespan Family Healthcare, LLC and have completed this form to the best of my ability and will not hold Lifespan Family Healthcare, LLC responsible for my errors or omissions.

Signature_____Date_____

IF YOU HAVE MEDICARE OR MAINECARE PLEASE READ:

MEDICARE/MEDICAID AUTHORIZATION

I requested that payment of Authorized Medicare Benefits be made to Lifespan Family Healthcare, LLC for any services furnished to me by Michael H. Clark, MD. I authorize any holder of information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agent's information needed to determine benefits. If I have other insurance, my signature authorizes releases of information to that insurer or agency. In Medicare/Medicaid assigned cases, the physician agrees to accept the determination of the carrier as payment in full and the patient is responsible for deductibles, coinsurance, and non-covered services.

Beneficiary
Signature_____Date_____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Lifespan Family Healthcare, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Lifespan Family Healthcare, LLC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Lifespan Family Healthcare, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Office Manager, 80 River Road, Newcastle, ME 04553.

I have the right to request that Lifespan Family Healthcare, LLC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With this consent, Lifespan Family Healthcare, LLC **may call my home** or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others. □ **yes** □ **no**

With this consent, Lifespan Family Healthcare, LLC **may mail to my home** or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential." □ **yes** □ **no**

With this consent, Lifespan Family Healthcare, LLC **may e-mail to my home** or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. □ **yes** □ **no**

The following person(s) may contact Lifespan Family Healthcare, LLC inquiring in regard to my health information. You have my permission to release information to them.

Name _____ Relationship _____

Name _____ Relationship _____

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Lifespan Family Healthcare, LLC may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

Lifespan Family Healthcare, LLC

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT INFORMATION (Please Print):

Name: _____ Date of Birth: _____

Social Security Number: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

RELEASE MY MEDICAL RECORDS FROM:

DR. Name: _____ Business Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

SEND MY MEDICAL RECORDS TO:

Lifespan Family Healthcare
Medical Records Coordinator
80 River Road
Newcastle, ME 04553

Phone: 207-563-3366 Ext 9
Fax: 207-563-3393

REASON: □ Selected new physician in the area □ Second opinion/Consult □ Other
□ Change of insurance □ Moving out of town _____

PORTION OF RECORDS TO BE RELEASED:

□ Entire Medical Record □ Other _____
_____

Restrictions: I understand that the recipient of this information may not use this information except for the express purpose identified above, unless another authorization is obtained from me or unless such or disclosure is specifically required or permitted by law.

Notice: Unless specified below this authorization is for full disclosure of all records, including clinical findings, diagnoses, treatments, assessments, recommendations for further care, names of all health care personnel, dates of hospitalizations and ambulatory visits, charges and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including AIDS/HIV information.

Exclusions (please initial): _____ Drug/Alcohol _____ Sexually Transmitted Disease
_____ HIV/AIDS _____ Mental Health/Psychiatric

Patient signature: _____ Date: _____

A photocopy of this release is as valid as the original

I understand that this consent is only for the specific purpose stated and may be revoked at any time. This consent expires automatically when its purpose has been accomplished.