

***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 - Holly - 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](http://www.lifespanfamilyhealthcare.com)

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**Patient Information**

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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 ( )
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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: \_\_\_\_\_

### Surgeries *You* Have Had:

- (Please include approx. date/year)
- Tonsillectomy \_\_\_\_\_
  - 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 : \_\_\_\_\_



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

*Lifespan Family Healthcare, LLC*

**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

