# LIFESPAN FAMILY HEALTHCARE

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

Keep this page for your records

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

**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 all 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: (please call your carrier if they are not currently listed)**

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

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" medical 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 pages
Consent for use of PHI and
Financial Policy (sign)
Records Release form (sign)

**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 prior to your appointment or Steve E Feder for pediatrics.

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** - Shane's Medical Assistant
**5** - Sandy - Billing / Admin / Referrals
**6** - Kelli - Dr. Clark's Medical Assistant
**7** - Chelsea – Medical Records/Scheduling
**0** - Becky - Front Desk/ Counseling Scheduling
**112**- Rebecca – Haley's Medical Assistant

**On-call number for after-hours medical questions**
877-401-5356

**Patient Portal – on our website:**
www.lifespanfamilyhealthcare.com

LIFESPAN
FAMILY HEALTHCARE

For Office Use only

**Patient Information**

| | | |
|---|---|---|
| Patient Name (Last, First, Middle): | | Preferred Name: |
| Gender: □ M □ F | Date of birth: | Social Security number: |
| Address (mailing): | | |
| Address (physical): | | |
| Home phone: | Cell phone: | Work Phone: |
| Email: | | |
| Contact preference (circle one or more): Home phone Cell phone Work phone Email Portal | | |
| Language: | Race: | Ethnicity: |
| Marital Status (circle one): S M W D O | Sexual orientation: | Pronouns: |

**Emergency Contact**

| | | |
|---|---|---|
| Name: | | |
| Relationship: | Home phone: | Cell phone: |

**Employment**

| | |
|---|---|
| Occupation: | If retired, previous occupation: |
| Employer name and phone number: | |

**Insurance information- Please provide a copy of your insurance card(s)**

| | | |
|---|---|---|
| Primary Insurance Carrier Name: | | PPO or HMO (circle one if known) |
| Member ID: | Group number: | |
| Subscriber name (who holds the insurance): | Relationship to patient: | Date of Birth: |
| Secondary Insurance Carrier Name: | | PPO or HMO (circle on if known) |
| Member ID: | Group number: | |
| Subscriber name: | Relationship to patient: | Date of Birth: |
| Guarantor – person to whom statements are sent: | | |

**Your health History**

Please check if you ever had any of the following:

- ❑ ADD/ADHD
- ❑ AID/HIV
- ❑ Abuse/Domestic violence
- ❑ Allergies/Hay fever
- ❑ Anemia
- ❑ Anxiety Disorder
- ❑ Arthritis
- ❑ Asthma
- ❑ Autism Spectrum Disorder
- ❑ Birth defects or inherited disease
- ❑ Bladder or kidney problems
- ❑ Blood diseases
- ❑ Blood transfusion
- ❑ Breast cancer
- ❑ Breast problems
- ❑ COPD
- ❑ Cancer _____
- ❑ Chicken pox
- ❑ Chronic ear infections
- ❑ Congestive Heart Failure
- ❑ Constipation
- ❑ Depression
- ❑ Developmental or Behavior disorders
- ❑ Diabetes: Type l or Type ll
- ❑ Difficulty Swallowing
- ❑ Diverticulitis
- ❑ Ear or hearing problems
- ❑ Eating disorders
- ❑ Eczema
- ❑ Endometriosis
- ❑ Fibromyalgia
- ❑ GI problems
- ❑ Gout
- ❑ Headache
- ❑ Heart Disease
- ❑ Heart Problems
- ❑ Hepatitis B or C (circle)
- ❑ High Cholesterol
- ❑ Hypertension
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Infertility
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Liver Disease
- ❑ Lung Disease
- ❑ MRSA exposure
- ❑ Mental Disorder
- ❑ Mental Illness
- ❑ Muscle, Joint or Bone problems
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Ovarian Cancer
- ❑ Polyps
- ❑ Pulmonary embolism
- ❑ Reflux/GERD
- ❑ Seizure/Epilepsy
- ❑ Skin Problems
- ❑ Stroke
- ❑ Thrombophilia
- ❑ Thyroid problems
- ❑ Tuberculosis
- ❑ Varicosities
- ❑ Vision or Eye Problems
- ❑ Other _____

**Surgery You have had**

Please include approx. date/year

- ❑ Tonsillectomy
- ❑ Sinus Surgery
- ❑ Appendectomy
- ❑ Gall Bladder removal
- ❑ Exploratory surgery
- ❑ Cataract removal
- ❑ Hysterectomy
  ovaries removed: No L R Both
- ❑ Mastectomy: L R
- ❑ Lumpectomy: simple or radical
- ❑ Hernia repair L R
- ❑ Coronary artery bypass
- ❑ Balloon angioplasty
- ❑ Pacemaker placement
- ❑ Hip replacement L R
- ❑ Knee replacement L R
- ❑ Back surgery
- ❑ Tubal Ligation
- ❑ Prostate surgery
- ❑ Vasectomy
- ❑ Other: please list

_____

_____

**Women:**

- ❑ Abnormal pap
- ❑ Tubal Pregnancy
- ❑ Diabetes in pregnancy
- ❑ Toxemia/preeclampsia

Total # pregnancies

Term: ___ Preterm: ____

Miscarriages: ___ Abortions:___

**Prescribed Medications that you are currently taking (print clearly):**

| Medication Name | Strength/Dose | Quantity taken | Times per day |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**List any Supplements, herbals or over the counter remedies you currently take**

_____
_____
_____
_____

**Allergies - to Medications**

| Name of Medication | Type of reaction (i.e. rash, itching, swelling, difficulty breathing, etc.) |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Other sensitivities or allergy you have experienced**

| Name of Allergen | Type of reaction |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Family Health History** **Unknown Adopted: _____**

Indicate if your family member is living or deceased and current illnesses or cause of death

| |
|---|
| Mother |
| Father |
| Brother/Sister |
| Brother/Sister |
| Brother/Sister |

**Does a family member HAVE OR HAD (check box): Please indicate family relationship M=mother F=father S=sister B=brother PGM or PGF = paternal grandparent MGM or MGF = maternal grandparent**

- ❑ High blood pressure _____
- ❑ High cholesterol _____
- ❑ Heart attack _____
- ❑ Osteoporosis _____
- ❑ Diabetes _____
  Type 1 or Type II
- ❑ Cancer (who and what type)
  _____ _____
  _____ _____
  _____ _____
- ❑ Thyroid problems _____
- ❑ Asthma _____
- ❑ Other _____
- ❑ Genetic Disease or "birth defect" _____
  What type: _____
- ❑ Rheumatoid Arthritis _____
- ❑ Anxiety panic attacks _____
- ❑ Psychiatric illness _____
- ❑ Depression _____
- ❑ Alcoholism _____
- ❑ Stoke _____
- ❑ Migraine headaches _____
- ❑ Gout _____
- ❑ Bleeding Disorders_____
- ❑ Epilepsy _____

**Preferred location**
Pharmacy: _____ Location/Town _____
Laboratory: _____
Imaging facility: _____

**Social History** (circle any that apply)
What is your spouse/significant other's name? _____
How many children do you have? _____

What type of diet are you following Regular Vegetarian Vegan Gluten Free Cardiac Diabetic Other
What is your exercise level? None Occasional Moderate Heavy
How many times per week do you exercise? 1-2 3-4 5-7

Do you or have your ever smoked tobacco? Never Former Current Everyday Currently Some Days
How many years have you smoked? _____ How many years since you quit? 1-5 6-10 11-15 16+
Do you or have you used any other forms of tobacco or nicotine? □ Yes □ No

What is your level of alcohol consumption? None Occasional Moderate Heavy
How many times per week do you consume alcohol? 1-2 3-4 5-6
How many days in the past year have you consumed 5 or more drinks? _____

Do you use any illicit or recreational drugs? □ Yes □ No

**Do you have an Advanced Directive/Living Will?** □ Yes □ No (if yes please provide a copy for our records)

**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

**List the names of any specialist you currently see and their specialty:**

_____

_____

_____

_____

**Please select a provider** (selection not guaranteed but based on availability)
□ Michael Clark
□ Shane Lovley
□ Haley Doak
□ Steve Feder (Pediatrics)

**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. 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.

With this consent, Lifespan Family Healthcare, LLC **may text my cell phone** to remind me of appointments, announcements, billing and about health notifications. □ **yes** □ **no**

With this consent, Lifespan Family Healthcare, LLC **may call my home/cell** or other alternative location and leave a message on voice mail or in person about 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. □ **yes** □ **no**

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

With this consent, Lifespan Family Healthcare, LLC may share my records with HealthInfonet* and/or Immpact for continuity of care. □ **yes** □ **no** *HealthInfonet is Maine's health information exchange. Immpact is the Maine state immunization program.

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

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone_____

**FINANCIAL POLICY**
As a courtesy to our patients, we file most insurance. Please be aware that some or all 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. 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. 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.

**MEDICARE/MEDICAID AUTHORIZATION**
I request that payment of Authorized Medicare Benefits be made to Lifespan Family Healthcare, LLC for any services furnished to me by the Providers at Lifespan. 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.

_____ _____
Signature of Patient or Legal Guardian Print Name of Legal Guardian, if applicable

_____ _____
Print Patient's Name Date

# 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**: (please provide accurate information to avoid delays)
DR. Name: _____ Business Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

**SEND MY MEDICAL RECORDS TO**:
Lifespan Family Healthcare
Medical Records Coordinator Phone: 207-563-3366 Ext 7
80 River Road Fax: 207-563-3393
Newcastle, ME 04553

**REASON**: □ Selected new physician in the area □ 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.