LIFESPAN
FAMILY HEALTHCARE

For Office Use only
OMT

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:		

Chief complaint:
Duration:
Cause (if known):
Prior evaluation for this complaint (Imaging) – please use attached records release to have copies sent to our office:
Prior treatment for this:
Have you ever had Osteopathic Manipulation?
Any underlying/prior musculoskeletal complaints?

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* **□ yes □ no** *HealthInfonet is Maine's health information exchange.

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

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: (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
80 River Road
Newcastle, ME 04553

Phone: 207-563-3366 Ext 7
Fax: 207-563-3393

REASON: □ Consultation/Procedure OMT □ Other ________________________________

PORTION OF RECORDS TO BE RELEASED:
□ Consults □ Imaging □ 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.