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 PCCM) / 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 - Information on becoming a new patient
2 - Becky – Scheduling/Front Desk
3 - Medication refills
4 - Ashley - Shane's Medical Assistant
5 - Sandy – Administration/Billing
6 - Kelli - Dr. Clark's Medical Assistant
7 - Chelsea – Referrals/Medical Records
9 - Office information
0 - Counseling Scheduling
112 - Rebecca – Haley's Medical Assistant
112 - Holly – Dr. Feder's Medical Assistant

For after-hours medical questions
Call the main number and be directed to the on-call service

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

LIFESPAN
FAMILY HEALTHCARE

For office use only

Patient Information – child/adolescent up to 17

Child Name (Last, First, Middle):			Preferred Name:
Gender: □ M □ F	Date of birth:		Social Security number:
Address (mailing):			
Address (physical):			
Summer/Winter Address:			
Home phone:	Cell phone (indicate if parent or patient):		
Email (include name of parent if than less age 16+):			
Contact preference (circle one or more): Home phone Cell phone Work phone Email Portal			
Name of mother:	Home phone:	Cell phone:	Occupation:
Name of father:	Home phone:	Cell phone:	Occupation:
Are parents: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced How long? _____			
Language:	Race:		Ethnicity:
Sexual orientation:		Pronouns:	

Emergency Contact

Name (if different from parents):		
Relationship:	Home phone:	Cell phone:

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:		

Prescribed Medications currently being taken (print clearly):

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

List any vitamins, herbals or over the counter remedies

_____

_____

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
_____	_____
_____	_____

Medical History – please describe any major medical problems and dates of occurrence

_____

_____

Hospitalizations/operations (with dates) – include any broken bones or severe injuries

_____

_____

List any specialist that child currently sees and reason:

_____

_____

Does your child currently have any of the following symptoms?

Constitutional/Endocrine
❒ Fever/chills/sweating
❒ Unusual weight loss/gain

Eyes
❒ Squinting/crossed eyes
❒ Difficulty seeing

Ears/Nose/Throat
❒ Problems hearing
❒ Mouth breathing/snoring
❒ Frequent runny nose
❒ Problem with teeth/gums

Respiratory
❒ Coughing/wheezing

Cardiovascular
❒ Tires easily with exercise
❒ Shortness of breath

Gastrointestinal
❒ Abdominal pain
❒ Nausea/vomiting/diarrhea
❒ Constipation
❒ Blood in bowel movement

Genitourinary
❒ Bedwetting
❒ Painful urination
❒ Penile/vaginal discharge

Neurological
❒ Headaches
❒ Weakness
❒ Clumsiness

Musculoskeletal
❒ Muscle or joint pain
❒ Other _____

Allergy
❒ Hay fever/itchy eyes

Skin
❒ Rashes
❒ Unusual moles

Psychiatric/Emotional
❒ Speech problems
❒ Anxiety/stress
❒ Sleep problems/nightmare
❒ Nail biting/thumb sucking
❒ Bad temper/breath holding
❒ Depression

Blood/lymph
❒ Unexplained lumps
❒ Easy bruising/bleeding

Family Health History **❑ Unknown adopted**

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 PGM = maternal grandparent

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

Preferred location
Pharmacy: _____ Location/town_____
Laboratory: _____
Imaging facility: _____

Social History
List siblings name and ages
_____
_____
_____

Current school: _____ **Grade**:_____

Child's diet: Regular Vegetarian Vegan Gluten Free Other? _____
Child's exercise level? None Occasional Moderate Heavy
How many times per week do they exercise? 1-2 3-4 5-7

For ages 12+
Do you or have your ever smoked tobacco? Never Current Everyday Currently Some Days
Do you or have you used any other forms of tobacco or nicotine? □ Yes □ No
Do you drink alcohol? None Occasional Moderate Heavy
Do you use any illicit or recreational drugs? □ Yes □ No

Vaccine Status: (Please provide any copies of vaccination records that you have)

Is there anything else you would like to share about your child?

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** email: _____

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.