

# 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  
United Healthcare / Harvard Pilgrim  
Aetna / Cigna / Maine Community Health Options  
Medicare (not currently taking) / Maine Care (not currently taking)  
Martin's Point Plans / 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

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**

**0** – Maddie - Scheduling/Front Desk  
**1** – Office and New Patient Information  
**2** – Counseling Scheduling  
**3** – Medication refills  
**4** – Ashley - Shane's Medical Assistant  
**5** – Madi/Rebecca – Dr Feder/Haley/Dr Scott's Medical Assistant  
**6** – Kelli - Dr Clark's Medical Assistant  
**7** – Mary Lou - Referrals/Medical Records  
**9** – Sandy – Billing/Administration

**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 with your insurance company to Michael H Clark prior to your appointment or Steve E Feder for pediatrics.**

### **For after-hours medical questions**

Call 563-3366 and be directed to the on-call service.

### **Patient Portal – on our website:**

[www.lifespanfamilyhealthcare.com](http://www.lifespanfamilyhealthcare.com)

For office use only

**Patient Information – child/adolescent up to 17**

Child Name (Last, First, Middle):		Preferred Name:	
Gender: <input type="checkbox"/> M <input type="checkbox"/> 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: <input type="checkbox"/> Married <input type="checkbox"/> Unmarried <input type="checkbox"/> Separated <input type="checkbox"/> 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

Musculoskeletal

- Clumsiness
- 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 PMG = maternal grandparent

- |   |  |
|---|--|
| <input type="checkbox"/> High blood pressure _____  | <input type="checkbox"/> Genetic Disease or "birth defect" _____ |
| <input type="checkbox"/> High cholesterol _____     | What type: _____   |
| <input type="checkbox"/> Heart attack _____         | <input type="checkbox"/> Rheumatoid Arthritis _____              |
| <input type="checkbox"/> Osteoporosis _____         | <input type="checkbox"/> Anxiety panic attacks _____             |
| <input type="checkbox"/> Diabetes _____             | <input type="checkbox"/> Psychiatric illness _____               |
| Type 1 or Type II                                   | <input type="checkbox"/> Depression _____                        |
| <input type="checkbox"/> Cancer (who and what type) | <input type="checkbox"/> Alcoholism _____                        |
| _____   | <input type="checkbox"/> Stroke _____                            |
| _____   | <input type="checkbox"/> Migraine headaches _____                |
| _____   | <input type="checkbox"/> Gout _____                              |
| <input type="checkbox"/> Thyroid problems _____     | <input type="checkbox"/> Bleeding Disorders _____                |
| <input type="checkbox"/> Asthma _____               | <input type="checkbox"/> Epilepsy _____                          |
| <input type="checkbox"/> 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 you 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?**

**How did you hear about us?**

**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 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**

With this consent, Lifespan Family Healthcare, LLC may share my records with ImmPact\*  **yes**  **no**

\*HealthInfonet is Maine’s health information exchange and 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. **Please make sure both parents are listed, if applicable.**

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

Signature of patient/parent or legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Name of person signing and relationship to patient: \_\_\_\_\_

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.