Dr. Marshall B. Sack, D.O. - Family Medicine – Psychiatry
Family Care Physicians, P.C.
39500 WEST TEN MILE ROAD, SUITE 100
NOVI, MICHIGAN 48375-2947
PHONE: (248) 476-0035 FAX: (248) 476-2418

NEW PATIENT INFORMATION FORM

Instructions: Please fill out as completely as possible. All information will be kept confidential

First Name: _____ Last Name: _____

Birth Date: _____ Sex: (circle one) M F S.S. #: _____

Address: _____ City: _____

State: _____ Zip: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Employer:_____ Employer Phone:_____

Employer Address: _____City:_____State:_____ Zip_____

Email: _____

(REFERRED BY: _____)

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ City: _____

State: _____ Zip: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

MEDICAL INSURANCE INFORMATION

Primary Insurance: _____ ID #: _____

Group #: _____ Subscriber's Name (if not self): _____

Subscriber's Birth Date: _____ Subscriber's Relationship to Patient: _____

Secondary Insurance: _____ ID #: _____

Group #: _____ Subscriber's Name (if not self): _____

Subscriber's Birth Date: _____ Subscriber's Relationship to Patient: _____

PLEASE BE ADVISED THAT YOU WILL RECEIVE SEPARATE BILLS FOR ANY LAB TESTS, X-RAYS AND OTHER ORDERS. THAT MAY BE ORDERED FOR YOU, AS THEY ARE DONE BY AN OUTSIDE SOURCE.

Assignment of Benefit-Financially Agreement

Assignment, Release and Agreement. I AM FINANCIALLY RESPONSIBILE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE. I hereby assign my benefit to be paid directly to my physician. I understand a monthly service fee of $2.50 will be charged on all balances 31 days and older. In the event of default, I agree to pay collection costs calculated at 40% of my account balance and any reasonable attorney's fees. I authorize this provider to release any and all information required to process this claim to my insurance company.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

Medical Release Contact: (optional)

List who we can release your medical information to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Medical History:

Current Medical Problems:

If you are being treated for any illnesses or medical problems by another physician, please describe the problem and indicate the name of the physician treating you.

Illness or Medical Problem:	Physician Treating You:

Illness and Medical Problems:

Illness:	X	Year:	Illness:	X	Year:	Illness:	X	Year:
Eye or eye lid infection	¤	_____	Heart murmur	¤	_____	Migraine headaches	¤	_____
Glaucoma	¤	_____	Other heart condition	¤	_____	Epilepsy	¤	_____
Other eye problems	¤	_____	Stomach/duodenal ulcer	¤	_____	Head Injury	¤	_____
Deafness	¤	_____	Diverticulitis	¤	_____	Stroke	¤	_____
Bronchitis	¤	_____	Colitis	¤	_____	Convulsions, seizures	¤	_____
Emphysema	¤	_____	Gout	¤	_____	Arthritis	¤	_____
Pneumonia	¤	_____	Yellow jaundice	¤	_____	Cancer or tumor	¤	_____
Allergies or Asthma	¤	_____	Liver trouble	¤	_____	Bleeding tendency	¤	_____
Tuberculosis	¤	_____	Hepatitis	¤	_____	Diabetes	¤	_____
Other lung problems	¤	_____	Hernia	¤	_____	Psoriasis	¤	_____
High blood pressure	¤	_____	Hemorrhoids	¤	_____	Mental illness	¤	_____
Heart attack	¤	_____	Kidney or bladder disease	¤	_____	Other	¤	_____
High cholesterol	¤	_____	Kidney stone	¤	_____			
Arteriosclerosis	¤	_____	Prostate problem	¤	_____			

Hospitalization:

Please list if any, operations or illnesses that you have been hospitalized. Don't include normal pregnancies.

Year:	Operation or Illness:	Hospital	City, State

Medications:

Please list all medications you are now taking, including those you buy without a doctor's prescription. (such as, OTC like aspirin and cold remedies, herbals & vitamins)		
1	5	9
2	6	10
3	7	11
4	8	12

Allergies and Sensitivities:

List anything that you are allergic to, such as certain foods, medications, dust, chemicals, soaps, household items, pollen, bee stings, etc. Also indicate your reaction.

Allergic to:	Reaction:	Allergic to:	Reaction:
1		4	
2		5	
3		6	

Social / Personal History:

Do you currently live: ¤ alone ¤ with friends ¤ with family ¤ with significant other	Marital Status: ¤ married, spouse's name:_____ ¤ separated ¤ divorced ¤ widowed ¤ never married
Last year completed in school:	Have you ever been rejected for health reasons by the military, an employer or an insurance company? ¤ yes, Explain: ¤ no
Were you sick but failed to get medical care in the last year? ¤ yes ¤ no	Did you miss more than ten days of normal activities last year due to illness? ¤ yes ¤ no

Smoking History:

Do you currently smoke: ¤ yes ¤ no	How many packs / day?	How many years have you smoked?
Do you chew tobacco? ¤ yes ¤ no	Are you a former smoker? ¤ yes ¤ no	

Alcohol Consumption:

Do you drink alcohol?
¤ yes ¤ no
Amount:
_____ Per ¤ day ¤ week ¤ month

Drug Use:

Do you use drugs?
¤ yes ¤ no
If yes:
Type(s): _____ Frequency:_____

Exercise Habits:

Do you exercise regularly? ¤ yes ¤ no
If yes, how often:_____

Car Safety:

Do you wear your seat belt? ¤ yes ¤ no

Health Risks:

Are there any health risks involved at your job, home environments or activities? ¤ yes (if yes, please explain below.) ¤ no

_____

Family Health History:

Please give the following information about your immediate family:			Have any blood relatives had any of the following illnesses? If so, indicate relationship by placing a "X" in the appropriate box.				
Relationship.	Age if living or Age at death.	State of health or cause of death.	Illness:	Father	Mother	Brother	Sister
Father:			Heart disease:				
Mother:			High blood pressure:				
Brother(s):			Cancer:				
			Diabetes:				
Sister(s):			Blood disease:				
			Epilepsy:				
Spouse:			Rheumatoid arthritis:				
Children:			Gout:				
			Glaucoma:				
			Tuberculosis:				
			Other: _____				
			Other: _____				

System Review:

Place a circle around each symptom that you have now or have had in the past and where applicable, fill in additional information.	
GENERAL:	Weakness Chills Fatigue Night sweats Change in weight/appetite Change in sleeping habits
SKIN:	Itching Rash Change in skin color Easy bruising
NERVOUS SYTEM:	Headache Dizziness Double vision Muscle weakness Numbness Loss of coordination
LUNGS:	Cough Wheezing Shortness of breath Spitting up blood Positive TB test Last chest X-ray, date:_____
HEART:	Chest pain Palpitations Trouble breathing Trouble climbing stairs Easy fatigue Ankle swelling
GASTROINTESTINAL:	Stomach pain Indigestion/heart burn Hard to swallow Vomiting Change in bowel habits Bloody stools
URINARY:	Pain on urination Blood in urine Frequent urination Previous infection Difficulty urinating
EYES:	Glasses/contacts Eye pain Excessive tearing Blurring or spots Last eye exam, date: _____
EARS:	Loss or decreased hearing Ringing Drainage
NOSE / THROAT / SINUSES:	Nose bleed Sore throat Hoarseness Post nasal drip Swelling
MOUTH:	Dentures Bleeding gums Toothache Last dental exam, date:_____
JOINTS & BACK:	Pain Swelling Stiffness Deformity
MUSCLES:	Pain Weakness Twitching
ENDOCRINE:	Excessively hot Excessively cold always thirsty always hungry
PSYCHOLOGICAL:	Nervousness Depression Unable to sleep Nightmares Memory Loss
IMMUNIZATIONS:	Tetanus, date: _____ German measles, date:_____ Influenza, date:_____ Pneumococcal, date: _____
MALE:	Hernia Discharge from penis Pain in testicles Sexual difficulties Sexually transmitted diseases
FEMALE:	Vaginal itching or burning Vaginal discharge Problem with menstrual periods Last menstrual period, date:_____ Last pap smear, date: _____ Methods of contraception: _____ Sexually transmitted diseases Sexual difficulties Pregnancy, number(s): _____ Lumps in breast Miscarriages or abortions, number: _____ Live births, number: _____ Problems during pregnancy Discharge from nipple Last mammography, date: _____

Notices / Consent / Policies / Disclosures

Informed Consent For Treatment:

Please read the following statements carefully. Ask any questions that will help you understand. Your signature at the bottom of this form indicates agreement with each statement, and gives our office permission to provide services as indicated below:

I authorize Marshall B. Sack, D.O. and Family Care Physicians, P.C. to provide treatment to me or my legal dependent. I understand that treatment does require a mutually agreed upon plan of service and that my participation in this plan is essential.

I understand that through the course of treatment, my physician will assist me in understanding procedures, possible risks and purposes of treatment. I understand that I may withdraw my consent to treatment at any time, but I will notify Marshall B. Sack, D.O. and Family Care Physicians, P.C. of my intent to do so. I further understand that I must comply with the treatment plan in order to receive continued services from the treating physician, Dr. Marshall B. Sack, D.O.

I understand that information will be made available to me regarding my rights and responsibilities. I will be given the opportunity to ask questions about the policies and services of Family Care Physicians, P.C. and I will receive a copy of this signed consent form if I ask.

Consent for Treatment with the Use of Prescription Medications (as documented in my medical records.

My physician has informed me that he recommends that I receive the medication/s listed in my medical records for the treatment of my symptoms. My physician has explained to me the risk of possible side effects. Although my physician has discussed the most common side effects associated with this/these medication/s and has given me a detailed description of these side effects, I understand I may experience other side effects. I further understand that I should promptly contact my physician or other member of his staff if there are any unexpected changes in my condition. I understand that I may not be compelled to take this/these medication/s and that I may request it to be discontinued at any time. However, I recognize that if I stop the medication/s, I may experience serious side effects/withdrawal and therefore I should consult with my physician before making such a decision. I also understand that although my physician believes that this medication/s will help me, there is no guarantee that it will be effective in the treatment of my particular symptoms. On this basis I authorize my physician to administer this/these medication/s at such intervals as he prescribes.

Financial Policies / Insurance Authorization:

Dear Patient:

Thank you for choosing us as your health care provider. This document is a summary of our financial policies, an explanation of your responsibilities and authorization to bill your insurance on your behalf for services provided to you. You may be responsible for co-payments, deductibles and services which may not be covered or considered a benefit under your policy. Your Insurance may deny claims for a variety of reasons:

1. The services provided may not be a benefit of your health insurance policy or may not be covered when provided by our office (mental health services, laboratory, etc.)
2. You may have exhausted your benefit for the services provided.
3. MEDCICAL NECESSITY or MEDICALLY NECESSARY generally means a determination based upon criteria and guidelines developed by your insurance carrier in consideration of generally accepted standards and practices. The services must meet all of the following criteria:

   a) it is generally accepted as necessary and appropriate for the patient's condition, given the symptoms, and is consistent with the diagnosis; and

   b) it is essential or relevant to the evaluation or treatment of the disease, injury, condition or illness and is not mainly for the convenience of the member or Physician; and

   c) it is reasonably expected to improve the patient's condition or level of functioning or, in the case of diagnostic testing, results are used in the diagnosis and/or management of the patient's care.

To Our Medicare/CMS Patients Only

Medicare/CMS will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a)(1) of the Medicare Law. However if Medicare determines that a particular service is not"reasonable and necessary" under their guidelines, payment may be denied. Medicare's guidelines for medical necessity are similar to those listed above.

Lifetime Beneficiary Claim Authorization

I request that payment of authorized Medicare/CMS benefits be made on my behalf to Family Care Physicians, P.C. for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made to my physician and authorizes the release of medical information necessary to pay the claim. If other health insurance coverage is indicated on approved claim forms or electronically submitted claims, my signature authorizes the releasing of the information to the insurer or agency shown. My physician agrees to accept the charge determination of the Medicare/CMS carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based on the charge determination of the Medicare/CMS carrier.

Patient/Responsible Party Statement

If my physician does not participate with my insurance company or my insurance company does not pay for the service provided, I agree to be personally and fully responsible for payment. I also accept responsibility for any co-payments and/or deductibles. I understand a statement of my charges and payments will be sent to my mailing address unless I otherwise indicate. I understand there is a $2.50 dollar statement fee if I don't pay at the time of service and a $25 fee for returned personal checks. I understand there may be missed appointment charges if I fail to notify you within 24 hours of my appointment. I have signed this form prior to any services rendered.

X _____. Date:_____.

Signature of Patient / Responsible Party

Family Care Physicians, P.C. Privacy Policies

This notice describes how the medical information about you may be used and disclosed and how you can get access to this information. Family Care Physicians, P.C. reserves the right to modify the privacy practices outlined in this notice at anytime. Please review carefully.

Uses and Disclosures:

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or Who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Family Care Physicians, P.C. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality care.

Law Enforcement: Your health information may be disclosed; to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures Require Your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. if you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of information:

Appointment Reminders: Your health information will be used by our staff to send or call you with appointment reminders.

Information About Treatments:

Your health information maybe used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest or benefit you.

Individual Rights:

You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your protected health information.
2. The right to receive confidential communications concerning your medical condition and treatment.
3. The right to inspect and copy your protected health information.
4. The right to amend or submit corrections to your protected health information.
5. The right to receive an accounting of how and to whom your protected health information has been disclosed.
6. The right to receive a printed copy of this notice.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right To Revise Privacy Practices:

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests To Inspect Protected Health Information:

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Receptionists or our Privacy Officer.

Complaints and Contact:

if you would like to submit a comment, compliment or complaint about our privacy practices or office in general, please do so by sending a letter to:

Patient Concerns
Family Care Physicians, P.C.
39500 West 10 Mile Road, Suite 100
Novi, Ml 48375

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized, discriminated or otherwise retaliated against for filing any such complaint(s).

Effective Date: This Notice is effective on and after the date you have signed.

Acknowledgment of Receipt: I have read the Notice of Privacy Practices for Family Care Physicians, P.C.

Name of Patient (Printed):_____.

X_____. Date:_____.

Signature of Patient or (Parent/Guardian*) *Required if Patient is a minor, under 18 years of age, or unable to sign this form.