Dr. Marshall B. Sack, D.O. - Family Medicine – Psychiatry
Family Care Physicians, P.C.

Name: _____ Birth Date:_____Sex: (circle one) M F

Address: _____ City: _____

State: _____ Zip: _____Marital Status: (circle one) S M D Social Security #_____

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

Employer:_____ Employer Phone:_____

Email: _____ Referred by:_____

**Preferred method of Appointment Confirmations:** ____ Text or ____ Email

## EMERGENCY CONTACT

Name: _____ Relationship: _____

Contact Number:_____

## 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: _____

Medical Release Contact: (optional) List who we can release your medical information to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

## Assignment of Benefit-Financial 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 and I will be charged a no show fee of $15.00 if I do not cancel my appointment ahead of time. 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.

**Informed Consent to Treat**

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.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

| Current Medical Problems: | Physician Treating You: |
|---|---|
| | |
| | |

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

| Year: | Operation or Illness | Year: | Operation or Illness |
|---|---|---|---|
| | | | |
| | | | |

Medications: List all medications you are now taking including Over The Counter ones bought without a prescription

| | |
|---|---|
| | |
| | |
| | |

Allergies and Sensitivities: List anything that you are allergic and indicate your reaction.

| Allergic to: | Reaction: | Allergic to: | Reaction: |
|---|---|---|---|
| 1 | | 3 | |
| 2 | | 4 | |

Social History:

| Do you currently smoke: ¤ yes ¤ no | Former smoker? ¤ yes ¤ no | Packs/day ? | How many years? | Exposed to Second Hand Smoke? ¤ yes ¤ no | Chew Tobacco? ¤ yes ¤ no |
|---|---|---|---|---|---|
| Do you drink alcohol? ¤ yes ¤ no | | Amount: _____ Per ¤ day ¤ week ¤ month | | | |
| Do you use drugs? ¤ yes ¤ no | | Type(s):_____Frequency:_____ | | | |

Health History:

| Please give the following information about your immediate family: | | | Have you or any immediate family had any of the following illnesses? Place X in boxes where illness is present. | | | | | |
|---|---|---|---|---|---|---|---|---|
| Relationship. | Age if living or Age at death. | Cause of Death | Illness: | Self | Father | Mother | Brother | Sister |
| | | | High Cholesterol | | | | | |
| Father: | | | Heart disease: | | | | | |
| Mother: | | | High blood pressure: | | | | | |
| Brother(s): | | | Heart Attack: | | | | | |
| | | | Diabetes: | | | | | |
| Sister(s): | | | Colon Cancer | | | | | |
| | | | Prostate Cancer | | | | | |
| Spouse: | | | Rheumatoid arthritis: | | | | | |
| Children: | | | Gout: | | | | | |
| | | | Glaucoma: | | | | | |
| | | | Mental Illness | | | | | |
| | | | Cancer (type in box) | | | | | |
| | | | Other:_____ | | | | | |
| | | | Other:_____ | | | | | |

Intials:_____

# Family Care Physicians, P.C. Privacy Policies

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).

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.

**Patient-Provider Partnership Agreement**
**Welcome to your Patient-Centered Medical Home. Thank you for choosing to partner with our medical practice for patient-centered care. We appreciate the trust and confidence you have placed in us for your care.**

## Primary Care Responsibilities

- **Listen** to your health concerns
- Provide **information** on chronic conditions and prevention programs
- Provide **flexible** and expanded office hours, schedule appointments within a reasonable time, and see patients as closely as possible to scheduled appointment time.
- Provide telephone **availability** to reach a clinical decision-maker for communication 24 hours per day, 7 days per week.
- **Coordinate** care provided by my practice team, other clinicians and health care institutions effectively to avoid duplication, delay and error.
- **Communicate** test and treatment results promptly and correctly.
- Provide information and advice regarding **preventative care**, maintaining wellness, self-management direction and counseling.
- **Assess** and discuss need for **community resource**. **Provide recommendation** to a resource relevant to your need.
- Provide **reminders** for follow up and preventative care.
- Maintain clinical information that allows us to participate in the development and maintenance of health records and **patient registries**, while protecting privacy and confidentiality.

## Patient Responsibilities

- **Communicate** openly
- **Participate** with your health care team in the development of treatment plans to improve your health
- Provide Health Care Team with **feedback** regarding Action and treatment plans.
- **Respect** the time of others by being on time for appointments and procedures.
- **Schedule and attend** appointments at intervals suggested by Health Care Team.
- **Involve yourself** in Physician's and other health care professionals' recommendations with respect to maintenance or improvement of your health and wellness.
- **Participate in action planning and goal setting with respect to maintenance or improvement of your health and wellness.**
- **Participate in developing and maintaining a comprehensive health record by authorizing delivery and circulation of clinical information to and from partnering clinicians and health care institutions.**

**Date:**_____

**Patient Name:**_____

***Patient / Guardian Signature:***_____