Family Care Physicians, P.C. - Anxiety and Depression Institute
Dr. Marshall B. Sack, D.O. and Associates - Family Medicine – Psychiatry

Please email completed form to forms@drmarshallsack.com, include a picture of your Drivers License and the Front and Back of your Insurance Card(s).

First Name: ____ Last Name: ____

Birth Date: ____ Sex: (check one) ☐ M ☐ F

Address: ____ Apt./Unit ____

City: ____ State: ____ Zip: ____

Marital Status: (check one) ☐ S ☐ M ☐ D ☐ W

Home Phone: ____ Cell Phone: ____

Email: ____ Referred By: ____

Preferred method of Office Communication: (check one) ☐ Text or ☐ Email

Employer: ____ Employer Phone: ____

EMERGENCY CONTACT

Name: ____ Relationship: ____

Contact Phone Number: ____

MEDICAL INSURANCE INFORMATION

Primary Insurance: ____ ID #: ____

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

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

☐ Commercial ☐ Medicare ☐ Medicaid

Secondary Insurance: ______ ID #: ______

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

Subscriber's Birth Date: ______

Subscriber's Relationship to Patient: ______

☐ Commercial ☐ Medicare ☐ Medicaid

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 RESPONSIBLE 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 $10 will be charged on all balances 31 days and older and I will be charged a no show fee of $25.00 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 associates of 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: ______

(Add Signature or Type Name to Electronically Sign)

DATE: ______

Patient Name: ____

Current Medical Problems:

Physician Treating You:	Treating You For:

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.

Medication:	Medication:

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

Check box if no allergies: ☐

Allergic To:	Reaction:	Allergic To:	Reaction:

Screening History: Have you had a:	Date Completed:		
Mammogram: ☐ Yes ☐ No ☐ N/A		Where:	
Pap-smear: ☐ Yes ☐ No ☐ N/A		Where:	
Colonoscopy: ☐ Yes ☐ No ☐ N/A		Where:	
Cologuard: ☐ Yes ☐ No ☐ N/A		Where:	
Bone Density: ☐ Yes ☐ No ☐ N/A		Where:	

Patient Name:

Social History:

Do you Currently Smoke:	Former Smoker:	Packs/day?	How Many Years?	Tobacco alternative (Vape)?	Chew Tobacco?
☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No

Do you Drink Alcohol?	
☐ Yes ☐ No	Amount: Per ☐ Day ☐ Week ☐ Month Type(s) of Alcohol:
Do you use Drugs: ☐ Yes ☐ No	Types of Drugs: Frequency:

Health History:

Please give the following information about your immediate family:

Relationship.	Age if living or Age at Death	Cause of Death
Father:		
Mother:		
Brother(s):		
Sister(s):		
Spouse:		
Children:		

Have you or any immediate family had any of the following illnesses?
(check the boxes where illness is present)

Illness:	Self	Father	Mother	Brother	Sister
High Cholesterol:	☐	☐	☐	☐	☐
Heart Disease:	☐	☐	☐	☐	☐
High Blood Pressure:	☐	☐	☐	☐	☐
Heart Attack:	☐	☐	☐	☐	☐
Diabetes:	☐	☐	☐	☐	☐
Colon Cancer:	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐
Rheumatoid arthritis:	☐	☐	☐	☐	☐
Stroke:	☐	☐	☐	☐	☐
Mental Illness:	☐	☐	☐	☐	☐
Cancer Type of cancer:	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

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: ____________

Patient or (Parent/Guardian*) (Add Signature or Type Name to Electronically Sign)

*Required if Patient is a minor, under 18 years of age, or unable to sign this form.

Family Care Physicians, P.C.
Anxiety and Depression Institute
Patient Health Questionnaire Depression (PHQ-9)

Date: ☐ Patient Name: ☐ Date of Birth: ☐

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please click the check mark by your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0 ☐	1☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless.	0 ☐	1☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much.	0 ☐	1☐	2 ☐	3 ☐
4. Feeling tired or having little energy.	0 ☐	1☐	2 ☐	3 ☐
5. Poor appetite or overeating.	0 ☐	1☐	2 ☐	3 ☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0 ☐	1☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0 ☐	1☐	2 ☐	3 ☐
8. Moving or speaking slowly that others could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0 ☐	1☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0 ☐	1☐	2 ☐	3 ☐
Add the score for each column	☐	☐	☐	☐

Total Score (add your column scores): ☐

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Please check one)

☐ **Not difficult at all.** ☐ **Somewhat difficult.** ☐ **Very Difficult.** ☐ **Extremely Difficult.**

Family Care Physicians, P.C.
Anxiety and Depression Institute
Patient Health Questionnaire General Anxiety Disorder (GAD-7)

Date: ☐ Patient Name: ☐ Date of Birth: ☐

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please click the check mark by your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0 ☐	1☐	2 ☐	3 ☐
2. Not being able to stop or control worrying.	0 ☐	1☐	2 ☐	3 ☐
3. Worrying too much about different things.	0 ☐	1☐	2 ☐	3 ☐
4. Trouble relaxing.	0 ☐	1☐	2 ☐	3 ☐
5. Being so restless that it's hard to sit still.	0 ☐	1☐	2 ☐	3 ☐
6. Becoming easily annoyed or irritable.	0 ☐	1☐	2 ☐	3 ☐
7. Feeling afraid as if something awful might happen.	0 ☐	1☐	2 ☐	3 ☐
Add the score for each column	☐	☐	☐	☐

Total Score (add your column scores): ☐

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Please check one)

☐ **Not difficult at all.** ☐ **Somewhat difficult.** ☐ **Very Difficult.** ☐ **Extremely Difficult.**

Family Care Physicians, P.C.
Anxiety and Depression Institute
Controlled Substance Agreement

Controlled substances medications (i.e. Stimulants, narcotics, tranquilizers, benzodiazepines, and barbiturates) are very useful for controlling both acute and chronic symptoms but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments, Because my physician is prescribing controlled substance medications to help manage my symptoms. I agree to the following conditions.

PATIENTS' RESPONSIBILITY
• I give permission for my physician to discuss all my diagnostic and treatment details with other physicians providing my medical care and with my pharmacists for purposes of maintaining accountability. This includes a copy of this contract.
• I will use only one pharmacy for all my prescription refills, whenever possible. I will register the name and phone number of this pharmacy with my physician.
• The number of refills on my medication is discussed during my appointment, I will not call for additional refills beyond those discussed. All medication changes will be face to face — not on the phone.
• I agree to bring the bottles of all the medications prescribed to each appointment.
• I agree to undergo random urine drug testing at the discretion of the physician. The test will show the presence of my prescribed medication but will also show any illicit drugs. The presence of illicit drugs or the absence of my prescribed medications will be considered a breech of this contract and therefore grounds for dismissal, Failure to comply with the test will be considered grounds for dismissal.
• I will not request or accept controlled substance medications from any other physician that is not expressly documented and discussed with Family Care Physicians. I will not give, share or sell my medications to any other person.

REFILLS OF MEDICATIONS
• Will be made only during regular office hours Monday through Friday. Refills will not be made after hours, on weekends, or on holidays. Will not be made as an "emergency" such as on Friday afternoon because I suddenly realize I will "run out tomorrow."
• Will not be made If I "run out early," or "lose a prescription," or "spill or misplace my medication," or "they are stolen." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. I am also responsible for keeping the medications in a secure location as to avoid their theft.

I will keep regularly scheduled appointments. If it is necessary to reschedule, I will give 24 hr notice or I may be charged a $25.00 fee.

TREATMENT CONSENT
I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substance, and that my physician will make treatment changes deemed appropriate.

(Female patients only) I am aware that if I plan to get pregnant or believe that I have become pregnant while taking these medications, I will immediately inform my physician to be weaned and discontinued from any medication the provider believes appropriate, I am aware that there could be some adverse affects on my baby.

I have been fully informed by Dr. Sack and associates regarding the potential for psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to their medications, necessitating a dose increase to achieve the desired affect, and that there is a risk of becoming physically dependent on the medication, This can occur if I am on the medication even for a short period of time. Therefore, If and when I need to stop taking the medications, I must do so slowly and under the medical supervision or I may have withdrawal symptoms. My doctor is not responsible for withdrawal syndrome if the medications are used inappropriately.

TERMINATION OF CARE
I understand that if I violate any of the above conditions, my treatment with controlled substance medications will be terminated immediately, without a 30-day notice. If the violation involves obtaining controlled substance medications from another person, or selling them to another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, I will be discharged from care Immediately. I am responsible for any withdrawal syndrome that may occur due to my misuse of the controlled substance medications and/or termination of my care.

I have read and agreed to all stipulations of this contract, All my questions have been answered to my satisfaction. I agree to comply fully with this contract, In addition, I fully accept the consequences of violating this agreement,

Date: ____________ Patient: ____________________

(Add Signature or Type Name to Electronically Sign)

Family Care Physician's P.C. - Anxiety and Depression Institute
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 needs.
- 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:

Print Patient Name:

Date of Birth:

Patient /Guardian Signature:

(Add Signature or Type Name to Electronically Sign)

Family Care Physicians, P.C.
Anxiety and Depression Institute
Social Determinants of Health

Patient Name: (first & last) ____________________

Patient Date of Birth: ____________________

Patient Primary Care Physician: ____________________

Today's Date: ____________________

As your Patient-Centered Medical Home, we are happy to partner with you, to help you and your family in time of need. From the answers below, we maintain a list of trusted community resources that care about you as much as we do.

Please answer the following questions.			
Within the past 12 months have you worried whether your food would run out before you got money to buy more?	☐ Often	☐ Sometimes	☐ Never
Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as part of a household?	☐ Yes	☐ No	
In the past year, has the utility company shut off your service for not paying your bills?	☐ Yes	☐ No	
In the last 12 months, did you skip medications to save money?	☐ Yes	☐ No	
In the last six months, have you ever had to go without health care because you didn’t have a way to get there?	☐ Yes	☐ No	
Do problems getting child care or elderly care make it difficult to work or study?	☐ Yes	☐ No	
Do you need any assistance with finding a local career center or job training?	☐ Yes	☐ No	
I have trouble understanding my doctor’s written instructions.	☐ Yes	☐ No	
How often do you feel lonely?	☐ Often	☐ Sometimes	☐ Never
Do you ever feel unsafe in your home or neighborhood?	☐ Yes	☐ No	
If you answered yes, would you like to receive assistance with any of these needs?	☐ Yes	☐ No	
Can we share this information with organization to whom we make referrals to address these needs	☐ Yes	☐ No	