WELCOME TO OUR PRACTICE

Family First Health Care Capac PLLC - 117 S. Main St. Capac, MI 48014 (810)395-4840

We are your Medical Home

You will notice some changes in the way we provide care, compared to other offices.

You may notice that:

We ask what your goal is, or what you want to do to improve your health.

We ask you to help us plan your care, and to let us know if you think you can follow the plan.

The care team members are doing more and/or different parts of the care.

We remind you when tests are due so that you can receive the best quality care.

We may ask you to have blood tests done before your visit so that the doctor has the results at your visit.

We are exploring methods to care for you better, including ways to help you care for yourself.

Seek our advice before you see other physicians. We may be able to care for you and we know about the strengths of various specialists.

Learn about wellness and how to prevent disease

Learn about your insurance so you know what it covers

We trust you, our patient, to:

Tell us what you know about your health and illnesses

Follow the care plan that is agreed upon, or let us know why you cannot so that we can try to help, or change the plan.

Tell us what medications you are taking and ask for a refill at your office visit when you need one.

Let us know when you see other doctors and what medications they put you on or change.

Ask other doctors to send us a report about your care when you see them.

Seek our advice before you see other physicians. We may be able to care for you and we know about the strengths of various specialists.

Learn about wellness and how to prevent disease.

Learn about your insurance so you know what it covers.

A Patient-Centered Medical Home (PCMH) is a trusting partnership between a doctor led health care team and an informed patient. It includes an agreement between the doctor and the patient that acknowledges the role of each in a total health care program.

Keep your appointments as scheduled, or call and let us know when you cannot.

Give us feedback so we can improve our services (Please fill out our survey in the waiting room or ask front desk for one)

We will continue to:

Provide you with a care team who will know you and your family.

Respect you as an individual–we will not make judgements based on race, religion, sex, age, disability, etc.

Give care that meets your needs and fits with your goals and values.

Have a doctor on call 24 hours a day and 7 days a week.

Take care of short illness, long term disease and give advice to help you stay healthy.

To improve your care we are using technology–like our Electronic Health Record and we will strive to continuously inprove.

Lab Test Results–

Please try to use laboratories and other test facilities we use regularly to ensure better communication. We strive to get test results to patients. Please schedule a follow up appointment to obtain results before leaving. If you have not received a call or notification by mail within 2 weeks, please contact our office for your results.

PRACTICE HOURS-

MONDAY,TUESDAY,WEDNESDAY 8-7, THURSDAY, FRIDAY 8-5

We are open some Saturdays from 8:00 a.m. to Noon

We are closed Sundays and Holidays

AVAILABLE COMMUNITY SERVICES

NEED HELP??? 2-1-1 is now available in St. Clair County. Dial 211 from any phone and you will be connected with a referral hotline that can connect you with Non-profit agencies in the area that can help with human, health and social needs. (i.e., utilities, housing, health, insurance, food, diapers, and more.) Available 24 hours a day and 7 days a week.

Comprehensive Quality of Care

Please be aware, in the course of providing your care, your health care information may be shared among other Providers involved in your care, as appropriate.

Remember when you visit your specialists, or you visit an urgent care or ER/Hospital:

Let us know when you see other doctors/go to urgent care/ER or were admitted to the hospital. Please bring in a current medication list and when going to the doctors or facilities, advise them to send all reports about your care to us (your Primary Care).

2 Locations to Better Serve You!

Urgent Care -
Please try calling our office first at (810)395-4840.
Or, please call our after -hours service first at (810)989-0947.
If closed during regular scheduled hours you can call our Armada office at (586)473-8082 to see if they have any openings.
We strive to accommodate patients who need more urgent care. Please call the above first to see if we can see you or guide your care. Often we might guide you to care that serves you well.
Emergency care is safer if we can guide the Emergency Department about your health situation.
As always, if life threatening call 9-1-1

Urgent Care Center:
Henry Ford Macomb
80650 Van Dyke Rd., Bruce, MI
(810)798-6410

McLaren Port Huron Emergency -
1221 Pine Grove Ave. Port Huron MI
(810)987-5000

McLaren Lapeer Regional
1254 N. Main St. Lapeer, MI
(810)664-4531

117 S. Main
Capac, MI
810-395-4840

Family First Health Care
Capac - Armada

22905 W. Main
Armada, MI
586-473-8082

Loren J. DeCarlo, D.O.
Paula J. Pretty, FNP
Karey S. Hartford, DNP, FNP
Pamela L. Kuzera, FNP

A caption describes the picture or graphic.

Family First Health Care
Capac - Armada

DEMOGRAPHIC FORM

Today's date:	

PATIENT INFORMATION

Name (Last, First, MI):				Marital status (circle one) Single / Mar / Div / Sep / Wid
Home phone no.: ( )	Cell phone no.: ( )	SSN:	Birth date:	Sex: ❑ M ❑ F
Mailing Address:		City & State:		ZIP Code:
Street Address (*if different from above)*:		City & State:		ZIP Code:

E-mail Address: Referred By:

***☐ Yes, I would like to be able to update my health history and have access to my medical records through FFHC's online patient portal.

Race ☐American Indian or Alaska Native ☐Asian ☐Pacific Islander ☐African American ☐Caucasian ☐Hispanic ☐Other

Ethnicity ☐Hispanic or Latin ☐Not Hispanic or Latin **Language** ☐English ☐Spanish ☐Interpreter Needed

Pharmacy:_____ **City:**_____ Phone Number:_____

*Secondary Pharmacy:*_____ City:_____ Phone number:_____

*Mail Order Pharmacy:*_____Phone Number:_____

INSURANCE INFORMATION

Are you the primary insured? ☐Yes ☐No. If no please fill out the insurance information below for the primary insured:

Name of primary insured:

SSN:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No		Patient's relationship to the primary insured: ☐Self ☐Spouse ☐Child ☐Other:_____	

Name of Secondary Insurance (if applicable):

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

May staff members in our office speak to these people on your behalf regarding your medical information? ☐Yes ☐No

Emergency Contact Name:	Relationship to patient:	Phone no.: ( )
Emergency Contact Name:	Relationship to patient:	Phone no.: ( )

Patient/Guardian signature *Date*

Family First Health Care
Capac - Armada

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Patient Address: _____

I request and authorize: _____

To release/obtain healthcare information to/from:

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ Other: _____

If the information described above includes information in any category below, *I specifically authorize the use or disclosure of such information.*

☐ Yes ☐ No STD results or HIV/AIDS testing, whether negative or positive
☐ Yes ☐ No Genetic Testing/Results
☐ Yes ☐ No Any records regarding drug, alcohol, or mental health treatment

I understand that I may revoke this authorization by notifying Family First at any time in writing, but if I do it won't have any effect on actions taken by Family First Health Care before they received the revocation.

I may refuse to sign this authorization. My health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form (Except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party). I have a right to receive a copy of this form after I have signed it.

By signing this authorization form, I authorize the use or disclosure of my protected health information as described above. I understand that information used of disclosed pursuant to this authorization may be disclosed by the recipient and my no longer be protected by federal or state law.

I have read this form and all my questions about this form have been answered. By Signing below, I acknowledge that I have read and accept all of the above.

Patient/Guardian Signature: Date Signed:

_____ _____

As part of our Patient Centered Medical Home orientation, we will ask you to acknowledge your agreement to the enclosed and we will acknowledge our agreement to you. Our goal has been to provide excellent care for you.

We desire to get better and better.

We appreciate the opportunity to provide you with medical services. The information that follows is designed to answer the questions most frequently asked by our patients. We want you to know our policies and methods of practice. If you have any questions, please ask us.

I understand and agree with this Patient Centered Medical Home Standard:

Printed Name:_____

Signature: _____

Form Reviewed By/Physician Signature:

_____Date_____

Family First Health Care – Capac
117 South Main St.
Capac, MI 48014
(810)395-4840
Fax (810)395-7551

Family First -Armada
22905 W. Main St.
Armada, MI 48005
(586)473-8082
Fax (586)473-8129

Family First Health Care
Loren J. DeCarlo, D.O.

Patient-Centered Medical Home

Right for our office.
Right for you.

What Are Your Options?

A Medical Home is a trusting partnership between a doctor led health care team and an informed patient. It includes an agreement between the doctor and the patient that acknowledges the role of each in a total health care program.

HELPING YOU MAKE THE RIGHT CHOICES

Over the next several months you may notice that-
We ask you to help us plan your care, and to let us know if you think you can follow the plan.
Written copies of care plans may be given in more complex illnesses.
The care team members are doing more and/or different parts of the care.
We remind you when tests are due so that you can receive the best quality care.
We may ask you to have blood tests done before your visit so that the doctor has your results at your visit.
We are exploring methods to care for you better, including ways to help you care for yourself.

We Trust You, Our Patient, To:

Tell us what you know about your health and illnesses.
Tell us about your needs and concerns.
Take part in planning your care.
Follow the care plan that is agreed upon-or let us know why you cannot so that we can try to help, or change the plan.
Tell us what medications you are taking and ask for a refill at your office visit when you need one.
Let us know when you see other doctors and what medications they put you on or change.
Ask other doctors to send us a report about your care when you see them.
Seek our advice before you see other physicians. We may be able to care for you and we know about the strengths of various specialists.
Learn about wellness and how to prevent disease.
Learn about your insurance so you know what it covers.
Respect us as individuals and partners in your care.
Keep your appointments as scheduled, or call and let us know when you cannot.
Pay your share of the visit fee when you are seen in the office.
Give us feedback so we can improve our services(We may survey you in the future to understand this better.

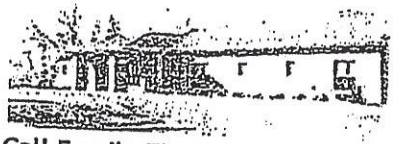
We Will Continue To:

Provide you with a care team who will know you and your family.
Respect you as an individual-we will not make judgments based on race, religion, sex, age, disability, etc.
Respect your privacy-your medical information will not be shared with anyone unless you give us permission or it is required by law.
Provide care given by a team of people led by your physician.
Give the care you need, when you need it.
Give care that meets your needs and fits with your goals and values.
Have a doctor on call 24 hours a day and 7 days a week.
Take care of short illness, long term disease, and give advice to help you stay healthy.
Tell you about your health and illnesses in a way you can understand.
To improve your care we are using technology -- like our Electronic Health Record and we will strive to continuously improve.

PRACTICE HOURS ARE (but subject to change)-
MONDAY,TUESDAY,WEDNESDAY 8-7, THURSDAY, FRIDAY 8-5
We are open most Saturdays from 8-1pm
We are closed Sundays and Holidays.

We strive to accommodate patients who need more urgent care. Please call us to see if we can see you or guide your care. Often we might guide you to care that serves you well. Emergency care is safer if we can guide the Emergency Department about your health situation.

Insurance Participation -- We participate in many health plans. Some health plans are better for preventative care than others; some health plans offer more choices. We review health plans with your interests in mind.



Call Family First Health Care for an appointment today!

117 S. Main
Capac, MI
810-395-4840

Family First Health Care
Capac - Armada

22905 W. Main
Armada, MI
586-473-8082

Loren J. DeCarlo, D.O.
Paula J. Pretty, FNP
Karey S. Hartford, DNP, FNP
Pamela L. Kuzera, FNP

Patient-Centered Medical Home

Physician Talking Points:

Have you heard that our office is a PCMH?

- A PCMH is an approach to providing comprehensive primary care that facilitates partnerships between patients, their physician and when appropriate, your family.
- APCMH operates with a whole person orientation where care is integrated and coordinated, and quality and safe are hallmarks.
- A PCMH means that the office of Loren Decarlo, D.O will continue to provide you with a highly dedicated medical team that will provide you with high quality medical care.

What does this mean for me, the patient?

- As we continue to build our Medical Home, you will begin to see some changes in the way we provide care, but many things will stay the same.
- As a PCMH, we will provide you with a single point of access to comprehensive care that addresses your full range of health care needs from check-ups to specialized services.
- It means that your care will be guided by a personal primary care physician who works with a team of health care professionals.
- It means that you will continue to receive care that is respectful and responsive to your needs, wants and values.
- It also means that you will have the education and support you need to make decisions, and participate in your own care.
- It means we will offer 24/7 care and will consistently deliver your care using the most current technology and evidence-based medicine.
- We want to encourage you to take a more active role in your healthcare decision making and managing your health and we are going to help you.

Additional Talking Points:

- As a PCMH, we will ask you to help us plan your care, and let us know if you think you can follow the plan.
- We will provide you with a care team who will know you and your family.
- We will respect you as an individual- we will not make judgments based on race, religion, sex age, disability, etc.
- We will respect your privacy, your medical information will be shared with anyone unless you give us permission, or it is required by law.
- We will give the care you need when you need it.
- We will give care this is based on quality and safety.
- We will take care of short illness and long-term disease.
- We will tell you about your health and illness in a way you can understand.

Family First Health Care

Capac - Armada

24 Hour Cancellation & "No Show" Fee Policy:

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Family First Health Care serves the right to charge a fee of $25.00 for all missed appointments/no shows, which are not cancelled within the 24 hours or with good cause.

"No show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Printed Name: _____

Signed Name: _____

Date: _____

Family First Health Care
Capac - Armada

Dear Patient,

Given the current climate in our country surrounding opioid pan medications, as an office have been compelled to evaluate our current prescribing habits and use of opioid pain medication among our clients. Every day, more than 90 American died after overdosing on opioids. The issue has become a public health crisis and names as a top priority by the US Department of Health & Human Services. It is our obligation as prescribers to do what we can to reduce the opioid epidemic that is claiming so many lives.

Although, there are certainly situations in which the use of opioid pain medications is appropriate, long term use of these medication is rarely indicated. If there is a situation in which opioids are prescribed to you for longer than 3 months, please be aware of the following:

1. You may be referred to a chronic pain management specialist.
2. You may be asked random urine drug screening.
3. These medications will not be prescribed over the phone.
4. Regular evaluations of the continued need of the medication will occur.
5. Certain medications such as those for anxiety and sleep may not be prescribed as they pose a dangerous risk of overdose when combined with opioids.
6. The medication may be stooped at any time if deemed no longer appropriate by the prescriber.

Our goal as an office is to provider each patient w/ safe and effective care. We than you in advance for your cooperation in assisting us to help combat the opioid crisis in our country. We ask that you sign this letter to acknowledge that the above expectations have been reviewed.

Sincerely,

Loren J. Decarlo, D.O
Paula Pretty, F.N.P
Karey Hartford, F.N.P.
Pam Kuzera, F.N.P.

Patient Signature _____

Date: _____

Family First Health Care
Capac - Armada

Patient Name _____

Date of Birth:_____

PEDIATRIC PATIENT HISTORY FORM

BIRTH HISTORY

Delivery: Vaginal Cesarean - due to:	Birth Weight:
Was this child premature? Yes No If yes, how many weeks? _____	Were there problems with this child's delivery? Yes No If yes, list:
Did this child have any unusual problems in the hospital such as trouble breathing, blue spells, yellow jaundice, trouble feeding, etc.? If yes, please list:	
Did this child need special treatment while in the hospital such as oxygen, transfusions, lights?	
Was (is) this child breast fed? No Yes	
Did (does) this child have any problems with breast feeding or formula feeding?	

SOCIAL HISTORY (Circle the appropriate answers)

Parents: Married Divorced Separated Single	
Siblings - please list:	
How many people live in your home? _____ Adults _____ Children	
Is your child currently enrolled in daycare or school? No Yes	
Does your child participate in regular exercise? No Yes explain:	
Does your child drink caffeine? No Yes	
Is there a swimming pool at home? No Yes	Any smokers at home? No Yes
Are there smoke detectors at home? No Yes	Carbon Monoxide detectors? No Yes
Any pets at home? No Yes If yes, please list:	
What is your water source?	Are guns kept in your home No Yes
Seat belts/car seats? No Yes	Helmets when biking? No Yes
Any issues we should be aware of? No Yes Please list:	

Parents Initials: _____ Date: _____

Medical Provider's Initials:_____ Date: _____

Patient Name _____ **Date of Birth:** _____

MEDICAL HISTORY	
Hospitalizations? None Yes - list:	
Surgeries? None Yes - list:	
Drug Allergies? None Yes - list:	
Did you bring a copy of child's immunization record? No Yes If no, please provide as soon as possible.	Hepatitis B Vaccine? No Yes
Has your child had chicken pox? No Yes If yes, when?	Has your child had chicken pox vaccine? No Yes
Any Chronic Illnesses: none yes - list:	Does your child see a specialist? No Yes Name?

REVIEW OF SYSTEMS		
Any lung problems?	None	Yes - list:
Any heart problems?	None	Yes - list:
Any kidney/urinary problems?	None	Yes - list:
Any bone/muscle problems?	None	Yes - list:
Any gastro-intestinal problems?	None	Yes - list:
Any brain/nervous system problems?	None	Yes - list:
Any genital problems?	None	Yes - list:
Any skin problems?	None	Yes - list:
Any eye/ear/nose/throat problems?	None	Yes - list:
Any developmental concerns or learining problems?	None	Yes - list:
Any behavioral problems or eating disorders?	None	Yes - list:
Any regular medications (over the counter or prescription)? Include does and frequency.		
Any medical issues we should be aware of? None Yes - list:		

Parents Initials: _____ Date: _____

Medical Provider's Initials:_____ Date: _____

Patient Name _____ **Date of Birth:** _____

FAMILY MEDICAL HISTORY						
	Child's Father	**Child's Mother**	**Sibling**	**Sibling**	**Grandparent**	**Other**
Year of Birth (if known)						
Year of Death (if known)						
Cause of Death (if known)						
Heart Disease						
High Blood Pressure						
Stroke						
High Cholesterol						
Anemia						
Diabetes (note if onset as Adult or Child)						
Asthma						
Tuberculosis						
Cystic Fibrosis						
Alcohol Abuse						
Drug Abuse						
Mental Problems						
Social Problems						
Psychiatric Problems						
Cancer (type)						
Kidney Disease						
Migraines						
Seizures						
Congenital Birth Defects						
Eating Disorder						
Other:						
Other:						

COMMUNICATION NEEDS:

Language if other than English: Child _____ Parent(s)_____
Any special communication needs? No Yes
If yes, explain:_____

PATIENT RIGHTS:

Is there anything we need to know about your religion or culture in order to care for your child? _____Y _____N
If YES, explain:_____

Parents Initials: _____ Date: _____

Medical Provider's Initials:_____ Date: _____