

# 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 improve.

## 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.

**DEMOGRAPHIC FORM**

Today's date:					
<b>PATIENT INFORMATION</b>					
Name (Last, First, MI):				Marital status (circle one) Single / Mar / Div / Sep / Wid	
Home phone no.: ( )	Cell phone no.: ( )	SSN:	Birth date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Mailing Address:		City & State:		ZIP Code:	
Street Address (if different from above):		City & State:		ZIP Code:	
E-mail Address:		Referred By:			
*** <input type="checkbox"/> 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.					
<b>Race</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other					
<b>Ethnicity</b> <input type="checkbox"/> Hispanic or Latin <input type="checkbox"/> Not Hispanic or Latin <b>Language</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Interpreter Needed					
<b>Pharmacy:</b> _____		<b>City:</b> _____		<b>Phone Number:</b> _____	
<b>Secondary Pharmacy:</b> _____		<b>City:</b> _____		<b>Phone number:</b> _____	
<b>Mail Order Pharmacy:</b> _____		<b>Phone Number:</b> _____			
<b>INSURANCE INFORMATION</b>					
Are you the primary insured? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient's relationship to the primary insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____			
Name of Secondary Insurance (if applicable):					
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
<b>IN CASE OF EMERGENCY</b>					
<b>May staff members in our office speak to these people on your behalf regarding your medical information?</b> <input type="checkbox"/> Yes <input type="checkbox"/> 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.

- |  |   |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | STD results or HIV/AIDS testing, whether negative or positive   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Genetic Testing/Results   |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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 or 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:**

\_\_\_\_\_



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

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.

## Patient-Centered Medical Home

Right for our office.  
Right for you.

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	

## 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**

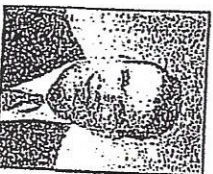
**We are closed Sundays and Holidays.**

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**

22905 W. Main  
Alameda, 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**

Dear Patient,

Given the current climate in our country surrounding opioid pain medications, as an office we have been compelled to evaluate our current prescribing habits and use of opioid pain medication among our clients. Every day, more than 90 Americans die after overdosing on opioids. The issue has become a public health crisis and is named 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 medications 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 stopped at any time if deemed no longer appropriate by the prescriber.

Our goal as an office is to provide each patient with safe and effective care. We thank 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**

---

## **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 reserves 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: \_\_\_\_\_



## NEW PATIENT MEDICAL HISTORY FORM

Full Name: \_\_\_\_\_

Date: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Age: \_\_\_\_\_

### ALLERGIES ☐ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

### MEDICATIONS

MEDICATIONS <i>(Please list ALL)</i>	DOSE <i>(Mg., pill, etc.)</i>	TIMES PER DAY

*If you need more room to list medications, please write them on a blank sheet of paper with the required information*

### HEALTH MAINTENANCE SCREENING TEST HISTORY

<b>CHOLESTEROL</b>	Date: _____	Facility/Provider: _____	Abnormal Result? Y N
<b>COLONOSCOPY/SIGMOID</b>	Date: _____	Facility/Provider: _____	Abnormal Result? Y N
<b>MAMMOGRAM</b>	Date: _____	Facility/Provider: _____	Abnormal Result? Y N
<b>PAP SMEAR</b>	Date: _____	Facility/Provider: _____	Abnormal Result? Y N
<b>BONE DENSITY</b>	Date: _____	Facility/Provider: _____	Abnormal Result? Y N

### VACCINATION HISTORY

Last Tetanus Booster or Tdap:	Last Pnuemovax ( <i>Pneumonia</i> ):
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine ( <i>Shingles</i> ):	



## PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer (type: _____)			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes (type: _____)			
Emphysema (COPD)			
Heart Disease			
High Blood Pressure (hypertension)			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal (kidney) Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

## SURGERIES

TYPE (specify left/right)	DATE	LOCATION/FACILITY

## WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_



## FAMILY MEDICAL HISTORY

☐ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

<b>✓ CHECK ALL THAT APPLY</b>	Alcohol/Drug Abuse	Asthma	Cancer (type: _____)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other: _____	Other: _____	Other: _____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other: _____																		

## SOCIAL HISTORY

Occupation (or prior occupation):	<input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> LOA <input type="checkbox"/> Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status (check one): <input type="checkbox"/> Single <input type="checkbox"/> Partner <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other: _____	
Do you have children? Y N	If yes, how many?

## OTHER HEALTH ISSUES

<b>TOBACCO USE</b>	Smoke Cigarettes? Y N (If you never smoked, please move to Alcohol /Drug Use)		
<b>Current:</b> Packs/day _____ # of Years _____	<b>Past:</b> Quit Date: _____ Packs/day _____ # of Years _____		
Other Tobacco (check one): <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Snuff <input type="checkbox"/> Chew			
<b>ALCOHOL/DRUG USE</b>	Do you drink alcohol? Y N	<input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N		Have you ever used needles to inject drugs? Y N	
Have you ever taken someone else's drugs? Y N			

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**OTHER HEALTH ISSUES continued...**

<b>SEXUAL ACTIVITY</b>	Sexually involved currently? Y N <i>(If no sexual history, please continue to Exercise)</i>	
Sexual partner(s) is/are/have been: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Birth control method: <input type="checkbox"/> None <input type="checkbox"/> Condom <input type="checkbox"/> Pill/Ring/Patch/Inj/IUD <input type="checkbox"/> Vasectomy		
<b>EXERCISE</b>	Do you exercise regularly? Y N <i>(If you answered no, please move to Sleep)</i>	
What kind of exercise?		<b>Duration:</b> How long (min.): _____ How often: _____
<b>SLEEP</b>	How many hours, on average, do you sleep at night <i>(or during the day, if working night shift)</i> ?	
<b>DIET</b>	How would you rate your diet? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Would you like advice on your diet? Y N
<b>SAFETY</b>	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N
Working smoke detector in home? Y N		If you have guns at home, are they locked up? Y N
Is violence at home a concern for you? Y N		Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N

**OTHER PROVIDERS/SPECIALISTS**

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other: _____		
Other: _____		

**ADDITIONAL INFORMATION**

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_