1912 Hayes Avenue
Sandusky, Ohio 44870
Phone: 419-502-2800

Family Health Services is a non-profit, Federally Qualified Health Center (FQHC) providing quality, affordable health care to all. Our doctors and nurse practitioners strive to improve the health of our community by providing primary care services to individuals and families of all ages and backgrounds. We have the unique ability to offer medical services to people from all walks of life to afford high quality health care services.

Worry about the finances later

We accept Medicaid, Medicare, and plans from most insurance carriers. We also use a sliding scale in our practice for patients who do not have insurance or whose coverage failed to take care of the bills. We adjust the prices of our Sandusky healthcare services based on your ability to pay.

Patient Centered Medical Home

What is a Patient Centered Medical Home (PCMH)?

At Family Health Services, we believe medical care is driven with the patient at the core of their care. We ensure decisions are made with respect to patient's wants and needs. Patients are educated on their level of understanding for medical decisions they will need to make for their health care. Care for patients is coordinated in all health care settings including referrals to specialists, therapists and home health care. Patients can access services with shorter wait times and "after hours" care via 24/7 electronic or phone access. We look forward to helping you obtain your highest level of health!

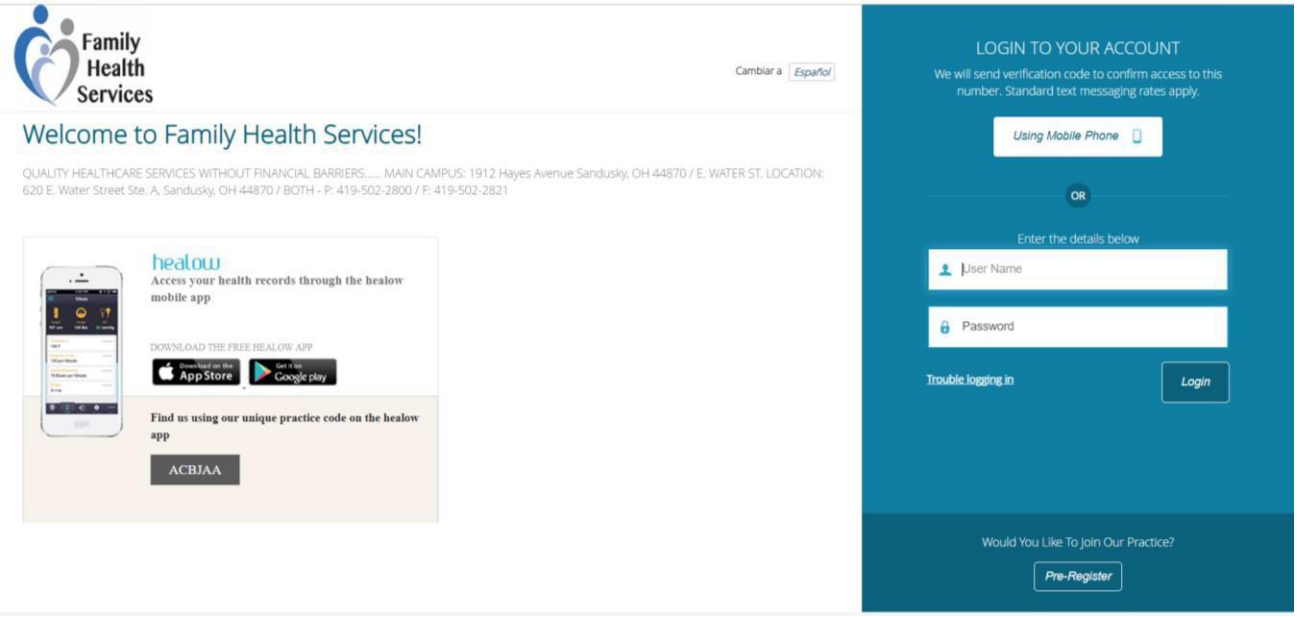
Follow the instructions below to access your patient portal and to use the HEALOW app.

Access the patient portal

1. Provide your (non-work) e-mail to the front desk.
2. You will receive an email from Family Health Services, follow the instructions in the email
3. Go to familyhs.org
4. Select PATIENT PORTAL (located at the bottom of the home page or at the top of the home page under Patient Services tab)

(Continue on back)

5. Click on Access The Patient Portal
6. You will come to the Welcome screen (see below). You can sign up for the patient portal and get the HEALOW App from here.



7. LOGIN TO YOUR ACCOUNT

With the user name and password you chose.

Get the Healow App Today

1. Download the Healow app from the Apple or Google App store using the links below.
2. Enter our practice code: **ACBJAA**
3. Enter your portal username and password to log on (or if you do not have a portal account- ask our staff about signing up)
4. Create a PIN to securely access your records.

If you want to set up your portal account or HEALOW app but are having trouble doing so, feel free to ask one of our staff for assistance. We look forward to helping you obtain your highest level of health!

Family Health Services

PLEASE COMPLETE ALL HIGHLIGHTED FIELDS

PATIENT INTAKE

We are a Federally Qualified Health Center and are required to ask the following questions. All information is confidential and used for reporting purposes only.

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI

PREFERRED NAME (NICKNAME)	GENDER
SOCIAL SECURITY NUMBER	☐ MALE ☐ TRANSGENDER FEMALE
DATE OF BIRTH	☐ FEMALE ☐ CHOOSE NOT TO DISCLOSE
	☐ TRANSGENDER MALE ☐ OTHER

PATIENT BILLING/MAILING ADDRESS

STREET ADDRESS OR PO BOX

CITY STATE ZIP CODE

PATIENT CONTACT INFORMATION

MOBILE PHONE	ALTERNATIVE PHONE #	EMAIL

PREFERRED METHOD FOR NOTIFICATION

☐ PHONE ☐ TEXT ☐ EMAIL ☐ AUTOMATED RECORDINGS

MAY WE LEAVE A MESSAGE ON YOUR PHONE? ☐ YES ☐ NO

PATIENT EMERGENCY CONTACT INFORMATION

NAME ADDRESS RELATIONSHIP CONTACT PHONE #

PREFERRED PHARMACY

NAME ADDRESS PHONE NUMBER

PARENTAL/GUARDIAN INFORMATION (IF PATIENT IS A MINOR)

NAME (LAST, FIRST, MI)

SSN # DATE OF BIRTH RELATIONSHIP TO PATIENT PHONE #

HOUSING STATUS

☐ CURRENT RESIDENT OF PUBLIC HOUSING ☐ SHELTER ☐ OTHER _____

☐ HOMELESS ☐ TRANSITIONAL

OVER →

PATIENT ADDITIONAL INFORMATION – FOR PUPOSES OF GRANT FUNDING ONLY

SEXUAL ORIENTATION –DO YOU THINK OF YOURSELF AS:

- ☐ STRAIGHT/HETEROSEXUAL
- ☐ LESBIAN
- ☐ GAY/HOMOSEXUAL
- ☐ BI-SEXUAL
- ☐ TRANSSEXUAL
- ☐ OTHER
- ☐ CHOOSE NOT TO DISCLOSE

ARE YOU OF HISPANIC OR LATINO ORIGN?

☐ YES ☐ NO

PRIMARY LANGUAGE

- ☐ ENGLISH
- ☐ SPANISH
- ☐ OTHER _____

INTERPRETER NEEDED?

☐ YES ☐ NO

RACE (You may mark more than one)

- ☐ AMERICAN INDIAN/ALASKAN NATIVE
- ☐ ASIAN
- ☐ BLACK/AFRICAN AMERICAN
- ☐ WHITE
- ☐ MORE THAN ONE RACE
- ☐ NATIVE HAWAIIAN
- ☐ OTHER PACIFIC ISLANDER
- ☐ OTHER NOT LISTED
- ☐ CHOOSE NOT TO DISCLOSE

ARE YOU A VETERAN OF THE ARMED FORCES?

☐ YES ☐ NO

HOUSEHOLD SIZE

☐ 1	☐ 4	☐ 7	☐ 10
☐ 2	☐ 5	☐ 8	☐ Other _____
☐ 3	☐ 6	☐ 9	

ESTIMATED HOUSEHOLD ANNUAL INCOME:

☐ 0 - 25,000	☐ 50,000 – 100,000	☐ 150,000+
☐ 25,000 – 50,000	☐ 100,000 – 150,000	

MARITAL STATUS

- ☐ SINGLE
- ☐ MARRIED
- ☐ DIVORCED
- ☐ WIDOW/WIDOWER
- ☐ LEGALLY SEPARATED
- ☐ LIFE PARTNER
- ☐ OTHER

MIGRANT WORKER STATUS

In the last two years, have you or a member of your family worked in fields, orchards, greenhouses, farms, vineyards, packing houses, or with animals such as cattle, dairy, sheep, poultry, fish hatcheries, etc.? ☐ Yes ☐ No

In the last two years, have you or your family **moved to another area** to work in fields, orchards, greenhouses, farms, vineyards, packing houses, or with animals such as cattle, dairy, sheep, poultry, fish hatcheries, etc.? ☐ Yes ☐ No

STRUCTURE INFORMATION

HOW DID YOU HEAR OF FAMILY HEALTH SERVICES?

☐ FROM A FRIEND OR PATIENT	☐ SOCIAL MEDIA (FACEBOOK, TWITTER)	☐ BILLBOARD
☐ COMMUNITY EVENT	☐ HOSPITAL OR OTHER PROVIDER	☐ NEWSPAPER
		☐ CONTACTED BY FHS

GUARANTOR/RESPONSIBLE PARTY INFORMATION

FIRST NAME:_____ MI:_____ LAST NAME: _____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE: _____

PHONE:_____ DATE OF BIRTH:_____ SSN#:_____

RELATIONSHIP TO PATIENT:_____ EMPLOYER: _____

PATIENT EMPLOYER

NAME OF COMPANY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TYPE OF BUSINESS: _____ OCCUPATION: _____

COMPANY PHONE: _____

EMPLOYEMENT STATUS: ☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ DISABLED

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY: _____

POLICY #: _____ GROUP #: _____

ADDRESS OF INSURANCE COMPANY: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EFFECTIVE DATE: _____ EXPIRATION DATE: _____

SECONDARY INSURANCE (IF APPLICABLE)

NAME OF INSURANCE COMPANY: _____

POLICY #: _____ GROUP #: _____

ADDRESS OF INSURANCE COMPANY: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EFFECTIVE DATE: _____ EXPIRATION DATE: _____

INSURANCE PAYMENT AUTHORIZATION AND RELEASE

I hereby authorize my insurance benefits to be directly paid to Family Health Services and acknowledge that I am financially responsible for any unpaid balances. Payment is expected at time of service. I also authorize Family Health Services to release any medical information necessary to process claims for payment.

PATIENT/GUARANTOR SIGNATURE _____ DATE _____

CONSENT FOR TREATMENT

I the undersigned certify that the information contained on this form is correct to the best of my knowledge. I hereby authorize Family Health Services medical staff to administer treatments, protocols and/or medications/vaccines, which are deemed necessary.

PATIENT/GUARANTOR SIGNATURE _____

DATE _____

Thank you very much!

Family Health Services

1912 Hayes Avenue
Sandusky, Ohio 44870
Phone: 419-502-2800
Fax: 419-502-2821

Authorization to Release Medical Records

PATIENT INFORMATION:

NAME:_____ DOB:_____ MRN: _____

ADDRESS: _____ SS# _____

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care	Military	Social Security/Disability
Insurance	Personal Care	Other: _____
Legal Purposes	School	_____

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical	Consultation Report	Emergency Room Record
Operative Reports	Discharge/Death Summary	Face Sheet
Lab/Path Reports	X-Ray Reports/Images	Other: _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:	**Family Health Services**	**FROM:**_____
	1912 Hayes Ave, Sandusky 44870	**ADDRESS:** _____
	(419)502-2800	**PHONE:** _____
	(419)502-2821	**FAX:** _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected. I understand that the specified drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire twelve (12) months from the date of my signature, unless I revoke the authorization prior to that time.

Date:_____ Signature _____

Patient or Legally Authorized Representative:

Printed Name:_____ Relationship: _____

HIPAA Authorization Form

Family Health Service (FHS) has taken measures to protect all of our patients' private medical information. FHS will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices. Your protected health information will be used by FHS or disclosed to others for the purpose of the treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be sued or disclosed. You may review the notice prior to signing this consent. You may also request a copy of the Notice of Privacy Practices for your own records. See the receptionist to receive a copy. You may request a restriction on the used or disclosure of your protected health information. FHS may or may not agree to restrict the use or disclosure of your protected health information. If FHS agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the Federal Privacy Standards. You may revoke this consent to the use and disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. PCHC reserves the right to modify the Privacy Practices outlined in the notice.

Please see the receptionist with any questions prior to signing this authorization form.

I,_____, DOB_____am authorizing the person/people listed below to obtain medical information about myself. I understand FHS is not responsible for the information provided as long as it is given to a person that I have listed below. Date of Birth must be provided so that our office can verify that we are speaking to the correct person.

Name:_____Date of Birth: _____

Name:_____Date of Birth: _____

I have reviewed this consent form & give my permission to FHS to Use & Disclose my health information in accordance of the Federal Privacy Standards.

Patient Signature:_____Date:_____

If guardian, relationship to patient: _____

OVER →

I,_____, do not authorize FHS to release any of my protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

Patient Signature:_____Date:_____

If guardian, relationship to patient: _____

I,_____, do authorize this emergency contact

_____to be called only in case of emergency. I understand none of my private information will be released.

Relationship:_____Phone: _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

May Family Health Services (FHS) leave a message on your answering machine or voicemail regarding the following: Scheduled appointments, premedication and instruction appointments

SELECT ONE

□ **YES**

□ **NO**

Assignment of Insurance Benefits, Release of Information and Authorization of Treatment. I, the undersigned authorize my insurance benefits to be paid directly to the provider of Family Health Services for services rendered. I understand that I am ultimately financially responsible for any balance due for approved and covered charges not paid by insurance. I hereby authorize Promise FHS to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claim submissions. I understand that payment is expected at the time services are rendered. A copy of this is as valid as the original.

Signature: _____

Date: _____

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying the Health Information Management Services/Medical Records Department OR the office administrator.

No-Show Policy

Quality care for our patients is our priority. Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions please let us know.

Definition of a "No-Show" Appointment

Family Health Services defines a "No-show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment
- Arrives more than 15 minutes late and is consequently unable to be seen

Impact of a "No-Show" Appointment

"No-show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-show" a scheduled appointment it:

- Potentially jeopardizes the health of the "no-showing" patient
- Is unfair (and frustrating) to other patients that would have taken the appointment slot
- Disrespects not only the provider's time, but also the time of the entire clinic staff

How to Avoid Getting a "No-Show"

1. **Confirm** your appointment
2. **Arrive** 5-10 minutes early
3. **Give** notice to cancel appointment prior to appointment time

1. Appointment Confirmation

Family Health Services will attempt to contact you one business day before your scheduled appointment to confirm your visit via automated phone call. Our automated phone system will try to call you up to five times to confirm your appointment.

2. Try to Arrive 15 Minutes Early

When you schedule an office visit with us, we would like you to arrive at our practice 15 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and or to complete any necessary paperwork before the scheduled visit.

3. Give Notice Prior to Your Appointment if You Need to Cancel

When you need to cancel or rebook a scheduled visit, we expect you to contact our office prior to the scheduled visit. This allows us to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patient.

Consequences of "No-Show" Appointments

If you miss 3 or more appointments within a year you will be required to make a Same-Day Appointment.

1. To make a Same-Day Appointment you will need to call the day you would like to be seen to see if any of these appointments are available.
2. Recurrent no-show appointments or non-complaint behavior may result in dismissal from Family Health Services.

I have read and understood the Family Health Services "No Show" Policy as described above.

_____ _____

Patient Signature Date

Keep for your records

Family Health Services

MEDICAL & BEHAVIORAL HEALTH SFS CO-PAYS									
	Level I		Level II		Level III		Level IV		Level V - No Discount
	0 - 100% of Federal Poverty Level (FPL)		101 - 140% of Federal Poverty Level (FPL)		141 - 180% of Federal Poverty Level (FPL)		181 - 200% of Federal Poverty Level (FPL)		Over 200% Federal Poverty Level (FPL) / No Income Information Provided
# of Family Members	If income is between:		If income is between:		If income is between:		If income is between:		If income is at or above:
1	$6,380	$12,880	$12,881	$18,032	$18,033	$23,184	$23,185	$25,760	$25,761
2	$8,620	$17,420	$17,421	$24,388	$24,389	$31,356	$31,357	$34,840	$34,841
3	$10,860	$21,960	$21,961	$30,744	$30,745	$39,528	$39,529	$43,920	$43,921
4	$13,100	$26,500	$26,501	$37,100	$37,101	$47,700	$47,701	$53,000	$53,001
5	$15,340	$31,040	$31,041	$43,456	$43,457	$55,872	$55,873	$62,080	$62,081
6	$17,580	$35,580	$35,581	$49,812	$49,813	$64,044	$64,045	$71,160	$71,161
7	$19,820	$40,120	$40,121	$56,168	$56,169	$72,216	$72,217	$80,240	$80,241
8	$22,060	$44,660	$44,661	$62,524	$62,525	$80,388	$80,389	$89,320	$89,321
Add for Each Additional Person	$2,270		$3,178		$4,086		$4,540		$4,540
Patient Payment	$20		$40		$60		$80		$150 at the time of service / Pt will be billed for remainder balance

If a Patient's insurance plan does *NOT* pay on a claim due to noncovered services, the patient will be responsible for their sliding fee scale copay amount.

If a Patients insurance deems an amount due as the Co-Pay, Co-Insurance or Deductible, the patient will owe the lessor of what is deemed by the insurance or the patients sliding fee scale amount.

Example: A patient is Level II ($60 copay), and their insurance has applied $85.66 towards the patients deductible. The patient will be charged the $60 copay for Level II copay, since that amount is lessor.

This serves as an acknowledgement that you received a copy of our Sliding Fee Scale, which is based off Federal Poverty Guidelines household size and income.

Keep for your records

NURSE VISITS & INSURED PATIENTS					
	Level I	Level II	Level III	Level IV	Level V - No Discount
	0 - 100% of Federal Poverty Level (FPL)	101 - 140% of Federal Poverty Level (FPL)	141 - 180% of Federal Poverty Level (FPL)	181 - 200% of Federal Poverty Level (FPL)	Over 200% Federal Poverty Level (FPL) / No Income Information Provided
Nurse Visits	$20	$40	$60	$80	$80 at the time of service / Pt will be billed for remainder balance
Insured Patients	$20	$40	$60	$80	
Balance after Co-pays/Deductible	$20	$40	$60	$80	
Insured Patients & Balance after copays/deductibles will be balance billed up to the assessed SFS Copay amount.					

This serves as an acknowledgement that you received a copy of our Sliding Fee Scale, which is based off Federal Poverty Guidelines household size and income.

Keep for your records

Family Health Services

Dental SFS CO-PAYS									
	Level I		Level II		Level III		Level IV		No Discount
	0 - 100% of Federal Poverty Level (FPL)		101 - 140% of Federal Poverty Level (FPL)		141 - 180% of Federal Poverty Level (FPL)		181 - 200% of Federal Poverty Level (FPL)		Over 200% Federal Poverty Level (FPL) / No Income Information Provided
# of Family Members	If income is		If income is between:		If income is between:		If income is		If income is at or above:
1	$6,380	$12,880	$12,881	$18,032	$18,033	$23,184	$23,185	$25,760	$25,761
2	$8,620	$17,420	$17,421	$24,388	$24,389	$31,356	$31,357	$34,840	$34,841
3	$10,860	$21,960	$21,961	$30,744	$30,745	$39,528	$39,529	$43,920	$43,921
4	$13,100	$26,500	$26,501	$37,100	$37,101	$47,700	$47,701	$53,000	$53,001
5	$15,340	$31,040	$31,041	$43,456	$43,457	$55,872	$55,873	$62,080	$62,081
6	$17,580	$35,580	$35,581	$49,812	$49,813	$64,044	$64,045	$71,160	$71,161
7	$19,820	$40,120	$40,121	$56,168	$56,169	$72,216	$72,217	$80,240	$80,241
8	$22,060	$44,660	$44,661	$62,524	$62,525	$80,388	$80,389	$89,320	$89,321
Add for Each Additional Person	$2,270		$3,178		$4,086		$4,540		$4,540
Diagnostic & Preventive (Exams and X-Rays)	$20		$60		$100		$120		$150 at the time of service / Pt will be billed for remainder balance
Restorative (Fillings), Periodontics & Extractions	$80		$120		$200		$240		$150 at the time of service / Pt will be billed for remainder balance
Prosthodontics & Endodontics (Root Canals and Crown and Bridge)	$800		$900		$1,000		$1,100		50% of total charge is due prior to service, remaining 50% of total charges due upon completion.
Deep Cleaning fee is per quad. (4 Quadrants for complete cleaning at $150 each)									
Prosthodontics, fee per arch. (Upper and Lower Dentures)									

If a Patient's insurance plan does *NOT* pay on a claim due to noncovered services, the patient will be responsible for their sliding fee scale copay amount.

If a Patient's insurance deems an amount due as the Co-Pay, Co-Insurance or Deductible, the patient will owe the lessor of what is deemed by the insurance or the patients sliding fee scale amount.

Example: A patient is Level II ($60 copay) for Diagnostic & Preventive visit, and their insurance has applied $85.66 towards the patient's deductible. The patient will be charged the $60 copay for Level II copay, since the amount is lessor.

This serves as an acknowledgement that you received a copy of our Sliding Fee Scale, which is based off Federal Poverty Guidelines household size and income.