

**HIGHLIGHTED AREAS MUST BE COMPLETED**

Please read carefully and complete the following statement acknowledging that yourself, your child, or your ward may receive services at Family Health Services School-Based Clinic.

Please include a copy of identification (license) if over 18 years old, or if patient is a minor please include their parent/court-appointed guardian's identification (license), as well as a copy of the insurance card. Copies can be made at the school or send picture of license & insurance cards to clinicinfo@familyhs.org.

<b>Student's Name:</b>	<b>Birth Date:</b>
<b>Address:</b>	<b>Student's Social Security #:</b>
<b>City:</b>	<b>Zip Code:</b>
<b>Student's Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____	

I acknowledge that I, myself / my child / my ward named above may receive the following services at the FHS School- Based Clinic:

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• Comprehensive Health Inquiry</li> <li>• Physical Examinations (general, sports, pre-employment)</li> <li>• Diagnosis and treatment for minor illnesses and injuries</li> <li>• Screening for select health problems (vision screening, hypertension, etc.)</li> <li>• Care of certain chronic conditions such as asthma and seizure disorders</li> <li>• Immunizations as needed (tetanus, rubella, etc.)</li> <li>• Virtual/Telehealth visits</li> </ul> | <ul style="list-style-type: none"> <li>• Individual health and wellness education services</li> <li>• Routine Lab Tests</li> <li>• Prescription Medications</li> <li>• Care for common pediatric/adolescent physical concerns (weight, acne, menstrual problems)</li> <li>• Pregnancy Testing</li> <li>• Diagnosis and treatment of sexually transmitted diseases</li> <li>• Mental Health Assessments measles/mumps,</li> <li>• Follow-up care as needed</li> <li>• Transportation to school-based clinic at 1 University Drive or other building if appt is pre-scheduled</li> </ul> |
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**Financial Responsibility:** If you have insurance, FHS will bill your insurance company. Any co-pays **will** be billed. If you are uninsured, our FHS Outreach & Enrollment Coordinator will be contacting you to explore possible assistance options.

**After Visit Summary:** If you/your child/ward receives services in the FHS School-Based Clinic, you/your child will receive an After-Visit Summary in a sealed envelope, if requested.

**Prescriptions:** All prescriptions will be electronically prescribed and sent to your preferred pharmacy identified in the School -Based Health Center History Form. Controlled prescriptions will need to be picked up directly from one of FHS main locations located at 1912 Hayes Ave. in Sandusky or 265 Benedict Ave. in Norwalk.

**I certify that I have read this notice and understand its content.**

**Signature of Patient or Responsible Party:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**HIGHLIGHTED AREAS MUST BE COMPLETED**

**Student/Patient Data**

PLEASE PRINT LEGIBLY

School:	Bowling Green State University – Firelands Campus
Degree/Program:	
Year:	

First Name:	
Middle Name:	
Last Name:	
Language:	

Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other						
Race:							
Date of Birth:	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 33%;">/</td> <td style="width: 33%;">/</td> <td style="width: 33%;"></td> </tr> <tr> <td>Month</td> <td>Date</td> <td>Year</td> </tr> </table>	/	/		Month	Date	Year
/	/						
Month	Date	Year					
Ethnicity:	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino						

**Adult Patient / Parent / Court -Appointed Guardian(s) Information**

First Name:	
Last Name:	
Phone Number:	
Guarantor for Medical Payment?	Date of Birth:
Social Security No.:	
Employer:	
Employer Address:	
Email Address:	

First Name:	
Last Name:	
Phone Number:	
Guarantor for Medical Payment?	Date of Birth:
Social Security No.:	
Employer:	
Employer Address:	
Email Address:	

**Insurance Information** – Financial Responsibility: If you have insurance, FHS will bill your insurance company. Any co-pays will be billed. If you are uninsured/underinsured, FHS' Outreach & Enrollment Coordinator will contact you to explore possible payment options.

**Primary Care Physician/Provider (PCP Data):**

<input type="checkbox"/> DO NOT have a PCP	
PCP Name:	
PCP Address:	
PCP Phone Number	

**ESTIMATED HOUSEHOLD ANNUAL INCOME:**

<input type="checkbox"/> \$0-\$25,000	<input type="checkbox"/> \$25,000-\$50,000	<input type="checkbox"/> \$50,000-\$100,000
<input type="checkbox"/> \$100,000-\$150,000 <input type="checkbox"/> \$150,000+		

Do not have Insurance:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete boxes below
Subscriber Name:	
Plan Name:	
Address:	
Group Number:	
Subscriber ID:	

TURN OVER



School-Based Health Clinic History Form

STUDENT/PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PARENT/LEGAL GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_
(Student 18 years old and older does not need parent/guardian signature)

(Please check ✓ all that apply)

ALLERGIES

- Food, Medications, Insects, Reaction, Seasonal, Animals

PAST MEDICAL HISTORY

- Allergies, Asthma, Ear Infections, Gastrointestinal, Other, Heart Disease, Neurological, Behavioral, Developmental

CURRENT MEDICATIONS

Table with 4 columns: Name of Medication, Dose, Amount Taken, Frequency Taken

PREFERRED RETAIL PHARMACY

Table with 3 columns: Name, Address, Phone Number

(Please check ✓ all that apply)

FAMILY HISTORY

Large table with 10 columns (Mother, Father, Sister, Brother, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather, Other Please list) and 18 rows of medical conditions.



**AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION**

Family Health Services  
1912 Hayes Avenue  
Sandusky, OH 44870

Phone: 419-502-2800  
Fax: 419-502-2820

**Patient:** \_\_\_\_\_

**Last 4 Digits of Patient's SSN:** \_\_\_\_\_

**School Program:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Current Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

For the purposes of this form, "my", and "I" mean the patient listed above whose record is maintained by Family Health Services.

I hereby authorize Family Health Services to release any and all health information that is contained in my patient records to Bowling Green State University – Firelands Campus for treatment and as otherwise needed for my safety and education at the sole discretion of Family Health Services. **I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse and/or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes as defined below.\* Release of Psychotherapy Notes requires a separate authorization.**

Once my health care information is released, the information may be re-disclosed by the recipient and may no longer be protected by law. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I agree to this authorization. I understand that the recipient of my health information may be charged for the service of releasing medical information.

This authorization form will automatically expire when Family Health Services is no longer providing school-based health care services to the students of Bowling Green State University – Firelands Campus, when I am no longer a student of Bowling Green State University – Firelands Campus, or when I revoke this authorization, whichever occurs first. I may revoke this authorization at any time, except to the extent that action has been taken in reliance upon it, through written notice sent to: Administrator, Family Health Services, 1912 Hayes Avenue, Sandusky, Ohio 44870.

\_\_\_\_\_  
**Signature of Patient/Patient's Personal Representative\*\***

\_\_\_\_\_  
**Date Signed**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Relationship, if not Patient**

\*Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.

\*\*If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **must** accompany the request (i.e., court-appointed guardian of the person, durable power of attorney for health care). Exception: Parent signing for a patient under the age of eighteen.



**Patient Acknowledgement and Consent Form**

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

**Date of Birth:** \_\_\_\_\_

On behalf of myself or my minor child or other patient named above, I acknowledge and consent to the statements made in this form. Changes or alterations to this form are not binding on Family Health Services.

**Consent to Health Care Services:** I am requesting that health care services be provided to me (or my minor child or the patient named above) at Family Health Services. I voluntarily consent to all medical treatment and health care-related services that the caregivers at Family Health Services consider to be necessary for me (or the patient named above). These services may include diagnostic, therapeutic, imaging, and laboratory services, including HIV testing. If I want any HIV testing to be performed anonymously, I will tell my Family Health Services caregiver. My blood may be used to perform routine quality assurance testing. I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments and examinations.

**Financial Responsibility:**

- 1. A. Subject to applicable law and the terms and conditions of any applicable contract between Family Health Services and a third-party payer, and in consideration of all health care services rendered or about to be rendered to me (or the above named patient), I agree to be financially responsible and obligated to pay Family Health Services for any balance not paid under the "Assignment of Benefits/Third Party Payers" paragraph below.  
OR, B. Subject to applicable law and the Family Health Services Sliding Scale Fee Policy, and in consideration of all health care services rendered or about to be rendered to me (or the above-named patient) I agree to be financially responsible and obligated to pay Family Health Services for the patient balances due;

AND,

- 2. I authorize all clinical providers who have provided care to me, along with any billing services, collection agencies or other agents who may work on their behalf, to contact me on my cell and/or other phone using automatic telephone dialing system or other computer assisted technology.

**Assignment of Benefits/Third-Party Payers:** In consideration of all health care services rendered or about to be rendered to me (or the above-named patient), I hereby assign to Family Health Services all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding Family Health Services' regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third-party payers, and other third-parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by Family Health Services to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third-party payers.

**Patient Rights and Responsibilities:** I have received a copy of the Family Health Services Patient Rights and Responsibilities handout.

**Uses and Disclosure of Health Information:** I have received Family Health Services' Notice of Privacy Practices. The Federal Privacy Standards explains how Family Health Services may use and disclose confidential health information that identifies me (or the above-named patient). I consent to let Family Health Services use and disclose health information about me (or the above-named patient) as described in the Federal Privacy Standards. In doing so I consent to the release of my (or the above-named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by Family Health Services, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent Family Health Services or provide assistance to Family Health Services for the purposes of securing payment from all parties who are potentially liable for payment for my (or the above-named patient's) health care, including for substance abuse, psychiatric care, or HIV, if applicable. I can revoke my consent in writing at any time except to the extent that Family Health Services has already relied on my consent.

**Communication:**

1. Family Health Services participates in one or more Health Information Exchanges. The Health Information Exchanges are electronic networks used to securely provide access to your health records. I voluntarily consent to allow access to my health information through the Health Information Exchanges. I can opt-out of this consent at any time in writing by notifying the Health Information Management Services/Medical Records Department.
2. I authorize Family Health Services to leave a message on my answering machine or voicemail regarding scheduled appointments, premedication and instruction appointments.
3. I authorize the following person(s) to obtain medical information about myself (or the above-named patient). Family Health Services is not responsible for the information provided if it is given to the below listed person(s).

Name of Person Allowed Health Information: \_\_\_\_\_

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

Name of Person Allowed Health Information: \_\_\_\_\_

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

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**Signature of Patient or Responsible Party**

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**Date**

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**Printed Name of Patient or Responsible Party**

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**Responsible Party's Relationship to Patient**