Family Health Services

1912 Hayes Ave
Sandusky, OH 44870
P: 419-502-2800

265 Benedict Ave
Norwalk, OH 44857
P: 419-219-9776

620 E. Water St Ste A
Sandusky, OH 44870
P: 419-502-2839

Welcome To Your Healthcare Home

Family Health Services (FHS) is a non-profit, Federally Qualified Health Center (FQHC) delivering quality, affordable healthcare 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 and thus help them afford high quality care.

Financial Assistance Available

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

Patient Centered Medical Home (PCMH)

At FHS, we believe medical care is driven by the patient, who is at the core of their own care. We ensure decisions are made with respect to their wants and needs. Patients are educated, with their level of understanding in mind, about any medical decisions they must make. Care for patients is coordinated across all 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 communications. 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 application.

Access the Patient Portal

1) Provide your (non-work) email to the front desk.
2) Follow the instructions in the email you receive from Family Health Services.
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 the Patient Services tab).
5) Click on Access the Patient Portal.
6) You will come to the Welcome screen. From there, you can sign up for the patient portal and download the HEALOW app.
7) Login to your account with the username and password you chose.

Get the Healow Application Today

1) Download the Healow Application from the Apple or Google App store.
2) Enter our practice code: **ACBJAA**
3) Enter your portal username and password to log in (or if you do not have a portal account, ask our staff about signing up).
4) Create a PIN to securely access your records.
5) If you want to set up your portal account or HEALOW application but are having trouble doing so, feel free to ask one of our staff members for assistance. We look forward to helping you obtain your highest level of health!

Family Health Services

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 intake forms and consents need to be updated annually on the anniversary date.

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI

PREFERRED NAME (NICKNAME- if applicable)

SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM/DD/YYYY)

GENDER
- ☐ MALE
- ☐ FEMALE
- ☐ TRANSGENDER MALE
- ☐ TRANSGENDER FEMALE
- ☐ DECLINE TO DISCLOSE
- ☐ OTHER: _____

RACE (You may mark more than one)
- ☐ AMERICAN INDIAN/ALASKAN NATIVE
- ☐ ASIAN
- ☐ BLACK/AFRICAN AMERICAN
- ☐ WHITE
- ☐ NATIVE HAWAIIAN
- ☐ DECLINE TO DISCLOSE
- ☐ OTHER:_____

ARE YOU A VETERAN OF THE ARMED FORCES: ☐ YES ☐ NO

MARITAL STATUS
- ☐ SINGLE
- ☐ MARRIED
- ☐ DIVORCED
- ☐ WIDOW/WIDOWER
- ☐ LEGALLY SEPARATED
- ☐ LIFE PARTNER
- ☐ OTHER: _____

PRIMARY LANGUAGE
- ☐ ENGLISH
- ☐ SPANISH
- ☐ OTHER: _____

INTERPRETER NEEDED:
- ☐ YES
- NO

SEXUAL ORIENTATION—DO YOU THINK OF YOURSELF AS:
- ☐ STRAIGHT/HETEROSEXUAL
- ☐ LESBIAN
- ☐ GAY/HOMOSEXUAL
- ☐ BI-SEXUAL
- ☐ TRANSSEXUAL
- ☐ DECLINE TO DISCLOSE
- ☐ 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

HOW DID YOU HEAR OF FAMILY HEALTH SERVICES?
- ☐ FROM A FRIEND
- ☐ COMMUNITY EVENT
- ☐ SOCIAL MEDIA (FACEBOOK, TWITTER)
- ☐ HOSPITAL OR OTHER PROVIDER
- ☐ BILLBOARD
- ☐ NEWSPAPER
- ☐ RADIO
- ☐ CONTACTED BY FHS

ADVANCE DIRECTIVES

Do you have a LIVING WILL?	Do you have a MEDICAL POWER OR ATTORNEY?
☐ Yes (please provide a copy)	☐ Yes (please provide a copy)
☐ No	☐ No

Family Health Services

PATIENT MAILING ADDRESS

STREET ADDRESS OR PO BOX		
CITY	STATE	ZIP CODE

HOUSING STATUS

- ☐ PRIVATE HOMEOWNER
- ☐ RESIDENT OF PUBLIC HOUSING
- ☐ SHELTER
- ☐ HOMELESS
- ☐ TRANSITIONAL
- ☐ OTHER: _____

HOUSEHOLD SIZE		ESTIMATED HOUSEHOLD ANNUAL INCOME:
☐ 1	☐ 4	☐ $0-$25,000
☐ 2	☐ 5	☐ $25,000-$50,000
☐ 3	☐ 6	☐ $50,000-$100,000
☐ OTHER: _____		☐ $100,000-$150,000
		☐ $150,000+

PATIENT CONTACT INFORMATION

MOBILE PHONE	ALTERNATIVE PHONE	EMAIL

PARENT/LEGAL GUARDIAN INFORMATION (IF PATIENT IS A MINOR)

NAME (LAST, FIRST, MI)			
SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP TO PATIENT	PHONE NUMBER
NAME (LAST, FIRST, MI)			
SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP TO PATIENT	PHONE NUMBER

EMERGENCY CONTACT INFORMATION

Name	PHONE	RELATIONSHIP TO PATIENT

PREFERRED PHARMACY ALL PRESCIPTIONS WILL BE ELECTRONICALLY PRESCRIBED AND SENT TO THE PREFERRED PHARMACY IDENTIFIED. CONTROLLED PRESCRIPTIONS WILL NEED TO BE PICKED UP DIRECTLY FROM AN FHS CLINIC.

NAME	CITY	PHONE NUMBER

Family Health Services

DO YOU HAVE INSURANCE (If yes, complete boxes below) ☐ YES NO

INSURANCE INFORMATION

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: _____

GUARANTOR/RESPONSIBLE PARTY INFORMATION (IF NOT PATIENT)

FIRST NAME: _____ MI:_____ LAST NAME: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ PHONE: _____ DATE OF BIRTH: _____ SSN#: _____ RELATIONSHIP TO PATIENT: _____ EMPLOYER: _____

PATIENT BILLING ADDRESS (IF DIFFERENT THAN MAILING ADDRESS)

STREET ADDRESS OR PO BOX		
CITY	STATE	ZIP CODE

Family Health Services

Authorization to Release and Obtain Medical Records

PATIENT NAME: _____ DOB: _____

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 record(s), and/or obtained and then contained in my patient record(s) from the facility named below for treatment and as otherwise needed for my safety. 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. Release of psychotherapy notes require a separate authorization. Once my healthcare 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 is not contingent upon whether or not you agree to this authorization.

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. 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.

- ☐ Authorization to Release Information To
- ☐ Authorization to Release Information From

Facility/Agency: _____

Street Address: _____

Phone: _____ Fax: _____

Type of Information: _____

Specific dates of service, if not all: _____

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

_____ _____

SIGNATURE OF PATIENT/REPRESENTATIVE DATE

_____ _____

PRINTED NAME RELATIONSHIP (IF NOT PATIENT)

Family Health Services

Patient HIPAA Acknowledgement and Consent Form

PATIENT NAME: _____ DOB: _____

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 with Family Health Services.

Consent to Health Care Services: I am requesting that healthcare 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 healthcare-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:

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";

OR,

B) Subject to applicable law and the Family Health Services Sliding Fee Policy, and in consideration of all health care services rendered or about to be rendered on 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,

C) 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 telephone using an automatic telephone dialing system or other computer assisted technology.

Assignment of Benefits/Third-Party Payers: In consideration of all healthcare 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 all insurance policies and/or responsible third-party payers of an amount not exceeding Family Health Services' regular and customary charges for the healthcare 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 the 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) 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, or consultants. This includes 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. 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, pre-medication, and instruction.
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: _____

DOB: _____

Name of Person Allowed Health Information: _____

DOB: _____

_____ _____

Signature of Patient or Responsible Party | Date

_____ _____

Printed Name of Patient or Responsible Party | Responsible Party's Relationship to Patient

Family Health Services

No Show Policy

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

Definition of a "No-Show" Appointment

We define a "No Show" appointment as any scheduled appointment in which the patient either:

1) Does not arrive.
2) 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-shows" to a scheduled appointment it:

1) Potentially jeopardizes the health of said patient.
2) Is unfair (and frustrating) to other patients that would have taken the appointment slot.
3) Disrespects not only the providers time, but also the time of the entire clinic staff.

How to Avoid Getting a "No-Show"

1) Confirm your appointment: Family Health Services will attempt to contact you, via an automated phone call, one week before your scheduled appointment to confirm your visit. Our automated phone system will attempt its call up to five times. Once your appointment is confirmed, the automated system will stop calling you. You will also receive a text message reminder about your appointment and a phone call from our clinic staff the day before your appointment.
2) Arrive early: When you schedule an office visit with us, we would like you to arrive at our practice 15 minutes prior to your scheduled time. This allows time for you and our staff to address any insurance or billing questions and/or complete any necessary paperwork before the scheduled visit.
3) Give notice to cancel appointment(s) prior to appointment time: 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 and gives another patient the opportunity to take the newly vacant appointment slot.

Consequences of "No-Show" Appointments

- If you miss 3 or more appointments within a 6-month period, you will only be allowed to schedule same-day appointments, and they must be approved by the clinical site director or management staff. Recurrent no-show appointments or non-compliant behavior may result in dismissal from Family Health Services.

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

_____ _____

Patient Signature Date

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	$0	$13,590	$13,591	$19,026	$19,027	$24,462	$24,463	$27,180	$27,181
2	$0	$18,310	$18,311	$25,634	$25,635	$32,958	$32,959	$36,620	$36,621
3	$0	$23,030	$23,031	$32,242	$32,243	$41,454	$41,455	$46,060	$46,061
4	$0	$27,750	$27,751	$38,850	$38,851	$49,950	$49,951	$55,500	$55,501
5	$0	$32,470	$32,471	$45,458	$45,459	$58,446	$58,447	$64,940	$64,941
6	$0	$37,190	$37,191	$52,066	$52,067	$66,942	$66,943	$74,380	$74,381
7	$0	$41,910	$41,911	$58,674	$58,675	$75,438	$75,439	$83,820	$83,821
8	$0	$46,630	$46,631	$65,282	$65,283	$83,934	$83,935	$93,260	$93,261
Add for Each Additional Person	$2,360		$3,304		$4,248		$4,720		$4,720
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 ($40 copay), and their insurance has applied $85.66 towards the patients deductible. The patient will be charged the $40 copay for Level II copay, since that amount is lessor.

NURSE VISITS & INSURED PATIENTS					
	Level I	Level II	Level III	Level IV	Level V - No Discount
Nurse visits	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	$10	$15	$20	$25	$30 at the time of service
Insured Patients & Balance after copays/deductibles will be balance billed up to the assessed SFS Copay amount.					

By signing below, I understand that Family Health Services offers a Sliding Fee Scale that is offered to all patients. You may retrieve a Sliding Fee Scale application from any of our receptionists.

Print Name: _____ Signature: _____ Date: _____

Family Health Services

DENTAL 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	$0	$13,590	$13,591	$19,026	$19,027	$24,462	$24,463	$27,180	$27,181
2	$0	$18,310	$18,311	$25,634	$25,635	$32,958	$32,959	$36,620	$36,621
3	$0	$23,030	$23,031	$32,242	$32,243	$41,454	$41,455	$46,060	$46,061
4	$0	$27,750	$27,751	$38,850	$38,851	$49,950	$49,951	$55,500	$55,501
5	$0	$32,470	$32,471	$45,458	$45,459	$58,446	$58,447	$64,940	$64,941
6	$0	$37,190	$37,191	$52,066	$52,067	$66,942	$66,943	$74,380	$74,381
7	$0	$41,910	$41,911	$58,674	$58,675	$75,438	$75,439	$83,820	$83,821
8	$0	$46,630	$46,631	$65,282	$65,283	$83,934	$83,935	$93,260	$93,261
Add for Each Additional Person	$2,360		$3,304		$4,248		$4,720		$4,720
Diagnostic & Preventive (Exams and X-Rays)	$20		$60		$100		$120		$150.00 due at the time of service / Pt will be billed for remainder balance
Restorative (Fillings), Periodontics & Extractions	$80		$120		$200		$240		$150.00 due 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 ($40 copay) for Diagnostic & Preventive visit, and their insurance has applied $85.66 towards the patient's deductible. The patient will be charged the $40 copay for Level II copay, since the amount is lessor.

By signing below, I understand that Family Health Services offers a Sliding Fee Scale that is offered to all patients. You may retrieve a Sliding Fee Scale application from any of our receptionists.

Print Name: _____ Signature: _____ Date: _____