Family Health Services	**Title:** Consent to Treatment & Financial Responsibility	ID #: FD1002 Effective: 12/17/2025 Page: 1
	PHONE: 419-502-2800 • FAX: 419-502-2821	

PATIENT NAME:	DATE OF BIRTH MM/DD/YYYY:

Consent to Health Care Services: I am requesting that Medical, Dental and/or Behavioral Health services be provided for the above-named patient at Family Health Services (FHS) and/or at a FHS School Based Clinic. I consent to all medical treatment, examinations and tests that are determined necessary for the above-named patient. I understand that that the practice of medicine and health care is not an exact science and that treatment may involve risks, injury or even death. No guarantees have been made regarding the outcome of any care, procedure or examination provided at FHS.

Financial Responsibility: Some services or procedures at FHS may not be covered 100% by Medicare, Medicaid or your insurance company. Plans can vary in what they consider medically necessary or eligible for payment. There are varying factors that can exist therefore FHS cannot guarantee any estimated charges or prior authorizations. These variables include but are not limited to:

Deductibles	Annual Maximums	Allowable Fee Limitations
Non-Covered Procedures	Frequency Limitations	

By signing below, I am acknowledging the following:

- Your policy and benefits are an agreement with you and Medicare, Medicaid or the insurance company. You may be responsible for any charges not paid by Medicare, Medicaid or the insurance company.

- You have provided FHS with your most current Medicare, Medicaid or insurance company information prior to your appointment. Failure to provide the most current information could result in inaccurate estimates/prior authorizations being provided.

- Treatment Plan Estimates or Prior Authorizations are a good faith attempt to inform patients/responsible parties of the cost of treatment based on known facts when the estimate/authorization was completed. As treatment progresses, there may be necessary changes made that could change the estimated cost or authorized amount.

- I have been made aware of the Sliding Fee Scale, and I can submit an application for review at any time by speaking with any staff member at FHS

- I am giving my consent for treatment for the above-named patient to all Medical, Dental and Behavioral Health services. All forms of treatment will be discussed between the provider, patient and/or parents/legal guardians of the patient, if a minor child.

- I understand that I may refuse any recommended treatment or procedure. If I choose to refuse treatment or fail to complete a treatment plan that was recommended for the above-named patient, I release FHS and its providers from liability for any consequences resulting from my decision.

- I authorize FHS to release medical information as necessary for treatment, payment or health care operations. This may include information concerning HIV/AIDS, sexually transmitted diseases, mental health and/or substance use conditions, consistent with Federal and State Law. I further authorize FHS to share

information with Medicare, Medicaid or insurance carrier (s), referring provider and others directly involved in the care of the above-named patient.

- I have received a copy and reviewed the FHS Notice of Privacy Practices & Patient Responsibilities
- I have received a copy and reviewed the FHS Notice of Nondiscrimination Policy

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY*:	DATE:
PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY*:	RELATIONSHIP TO PATIENT:

*** IF SOMEONE OTHER THAN THE PATIENT IS SIGNING THIS FORM, A COPY OF LEGAL PAPERWORK VERIFYING THE PATIENT'S PERSONAL REPRESENTATIVE MUST ACCOMPANY THE CONSENT (I.E. COURT APPOINTED GUARDIANSHIP OF THE PATIENT OR DURABLE HEALTHCARE POWER OF ATTORNEY). THE ONLY EXCEPTION IS IF A PARENT IS SIGNING FOR A MINOR CHILD.**

☐ Check this box if verbal consent was given by the patient. If verbal consent was given, please list who received the verbal consent and who witnessed the patient giving verbal consent.

Name of Person Receiving Verbal Consent:	Date Verbal Consent Was Given:
Name of the Witness to Verbal Consent Being Given:	Date Verbal Consent Was Given:

_____ By initialing here, I am consenting to my minor child or the patient named above, to bring self to Primary Care and Behavioral Health appointments without an adult present. Minor children must be at least 14 years of age or older.

_____ By initialing here, I am consenting to my minor child or the patient named above, to bring self to Dental appointments without an adult present. Minor children must be at least 17 years of age or older.

_____ By initialing here, I am stating that I **do not** wish for my child to be seen at a FHS School Based Clinic.

PRISMA Consent:

Select the appropriate consent option to allow patient data exchange with external hospitals and practices. The external data that is successfully retrieved will be viewable in PRISMA.

☐ OPTED IN: Send and Receive Documents	☐ OPTED IN: Receive Documents Only
☐ OPTED IN: Send Documents Only	☐ OPTED OUT