Family Health Services

Dental Patient Policy Form

Patient Name: _____

Please read and initial:

Family Health Services Dental Office is a general dental practice and requires the assistance of our partnering providers to deliver your care. You may be provided with a list of suggested specialty care providers if our general dentists are not able to provide the following services: root canals, complex extractions, pediatrics, periodontal treatments, and other services. _____

The Family Health Services Dental Office maintains a firm late and cancelled appointment policy to deliver as much care as possible to as many patients as we can each day. Patients late for their appointment and patients that fail to keep their appointment take away an opportunity for another patient to receive care. _____

Please notify the office as soon as possible if you are unable to keep your appointment. Canceling appointments less than 24 hours in advance could result in a "no show." After three times of not showing up for your appointment without first calling to cancel, you may no longer be seen at Family Health services Dental Office. As a courtesy we will try to provide a confirmation call and/or text, however it is the patient's responsibility to remember their appointments. _____

To avoid having your appointment given to another patient please call us if you are running late. After 3 times of being late or having a canceled appointment, patients may be dismissed from the practice for continuing dental care. Treatment may be referred out after 2 cancellations/missed specialty treatment appointments. _____

All patients will be scheduled with an available provider. Patients can request a specific provider depending on provider availability. _____

To support our continued quality of care, Family Health Services will be collecting a fee of $150 during check- in for all patients uninsured and/or not on the sliding fee. If the total fee exceeds $150 the remaining balance will be mailed out to the patient. You may meet with our Financial counsler to set up payment plans._____

Advanced procedures such as crowns, root canals, and dentures will have a different rate; please speak to our dental patient support staff about the price of these advanced procedures. For all dentures/partials/crowns, if the patient's insurance does not cover this service, the patient is fully responsible for upfront payment of 50% of service at initial appointment and 50% when services are completed.You may meet with our financial counsler to set up a payment plan if needed. Failure of payment may result in the rescheduling of an appointment. _____

You have the responsibility to cooperate with Family Health Services so that we may administer benefits in accordance with your dental plan. Since Family Health Services has many different payer sources, it is your responsibility to know what your dental plan coverage allows, the deductibles and co-insurance payments. You have the responsibility to become familiar with your dental plan benefits, policies, and procedures by reading materials distributed by the respective dental plan. For clarification, you should call the customer service department of the respective dental plan with any questions. _____

We always conduct ourselves in a professional manner and contribute to the maintenance of a professional environment. We do our best to provide each patient with compassion and quality care our goal is to provide a safe environment for staff and patients, we do not tolerate any inappropriate behavior towards Dental office staff this includes, but not limited to: verbal abuse, threats, assaults, drug-seeking behavior and, sexual harassment. _____

As a courtesy to everyone's privacy and safety, we respectfully request limiting the number of companions to 1 in out treatment rooms. Standing space is limited and we welcome you to remain in our reception area. Exceptions include children under 10, special needs patients, and those that need translation. All other exceptions will be at the decision of the dentist. Failure to comply with this may result in the rescheduling of your dental appointment. _____

Failure to comply with any of the above policies may result in a referral to another Health Center and dismissal from our Dental office.

I have read the above and agree to the terms provided.

Signature_____ Date_____

Medical and Dental History
Family Health Services

Quality healthcare services without financial barriers

Name _____ Date of Birth _____ Patients name and DOB verified ? Yes/ NO

1	Allergies to medications, drugs, or latex.	Yes / No	17	Artificial joints?	Yes / No	34	Behavior problems or special needs? Yes / No
2	WOMEN: Are you taking birth control pills?	Yes / No	18	Difficulty breathing?	Yes / No	35	Are you in severe tooth pain today? Yes / No
3	WOMEN: Are you or could you be pregnant or nursing? *Due Date:*_____	Yes / No	19	Seizures? What causes it? _____	Yes / No	36	What medications are you currently taking, including psychiatric _____ Yes / No
4	Do you have HIV/AIDS?	Yes / No	20	Asthma, TB, emphysema, other lung diseases?	Yes / No		
5	Herpes or Cold Sores?	Yes / No	21	Do you smoke or use tobacco products?	Yes / No	37	Have you been hospitalized or had a serious illness in the last 3 years? If yes, why: Yes / No
6	Hepatitis, other liver disease?	Yes / No	22	Are you taking recreational drugs?	Yes / No		
7	Kidney Disease or Dialysis?	Yes / No	23	Persistent cough, coughing up blood?	Yes / No	38	Do you have or have had any other diseases or medical problems NOT listed on this form? If so, please explain: Yes / No
8	Diabetes?	Yes / No	24	Fainting spells? Dizziness? Blurred vision?	Yes / No	39	Are you being treated by a physician now? Yes / No
9	High blood pressure?	Yes / No	25	Difficulty swallowing?	Yes / No		*Physician Name*_____
10	High Cholesterol?	Yes / No	26	Have you had problems with prior dental treatments?	Yes / No	40	Have you been administered fluoride varnish by your PCP? If so, when? _____ Yes/No
11	Anemia? Bleeding problems, bruising easily?	Yes / No	27	Swollen ankles?	Yes / No		
12	Heart murmur? Rheumatic fever?	Yes / No	28	Stomach problems, ulcers?	Yes / No	41	Are you having fluoride exposure through drinking water, supplements, or toothpaste? Yes / No
13	Heart disease? Heart attack, heart defects ?	Yes / No	29	Recent weight loss, fever, night sweats?	Yes / No		
14	Prosthetic heart valve?	Yes / No	30	Radiation treatments? Chemotherapy?	Yes / No	42	How often do you snack on sugary foods or drinks throughout the day?
15	Pacemakers?	Yes / No	31	Excessive thirst? Dry mouth?	Yes / No		
16	Stroke, hardening of arteries?	Yes / No	32	Have you had Psychiatric care?	Yes / No	43	Do you encourage proper dental health (brushing, flossing, mouthwash) in your household? Yes / No
			33	Are you currently, or in the past, in pain management?	Yes / No	44	Are you currently taking or previously taken Suboxone? Yes / No

1st Visit and Recall: Comprehensive Exam, Limited or Emergency Exam with Neccessary x-rays → **2nd Visit Type *(Based on Availability)*:** Cleaning, Deep Cleaning, Sealants ↔ **3rd Visit Type *(Based on Availability)*:** Fillings, Crowns, Build-ups, Dentures, Extractions, Bone Grafting, Root Canals and/or Other Procdures

I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medications. I understand that, in the course of dental treatment, it may become necessary to perform additional procedures which are not known to be needed at the start of the treatment. I request and give my consent for my dentist to perform such procedures at his/her discretion if needed during the dental appointment.
I affirm that I am not a carrier of COVID-19 nor infected with COVID-19 to the best of my knowledge. I do voluntarily assume any and all reasonable medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of my treatment as a result of the COVID-19 pandemic. I understand that Family Health Services is following CDC guidelines as far as treatment protocols and infection control.
I give consent for my child to participate in care at "Family Health Services," which may provide the following dental treatment as needed: X-rays, dental exam, fluoride treatments, dental cleaning, sealants (protective covering over teeth), fillings (white and silver), extractions (pulling teeth), pulpotomies (removing tooth nerves), and stainless steel crowns (caps). For some procedures, local anesthetics or tooth numbing medicine may be used.

Signature _____ Date _____

Visit Type 1

EXAM	ICD-10	
D0120	Z01.21	Periodic
D9998	or	*Caries Present*
D9997		*Caries NOT present*
D0001	or	*Phase 1 Care Pending*
D0002		*ALL Phase 1 Care Complete*
D0140	Z01.21	Limited
D0140/D999	Z01.21	Teledental
D0145	Z01.21	Oral Evaluation < 2 yrs of age
D0150	Z01.21	Comp
D0170	Z01.21	Re-eval Limited
D0180	Z01.21	Perio Ex.

XRAYS			
D0210	Z98.811	FMX	
D0220	Z98.811	1st PA	Tooth#:
D0230	Z98.811	Each PA	Tooth#:
D0270	Z98.811	1st BW	
D0272	Z98.811	2-BW's	
D0274	Z98.811	4-BW's	
D0330	K00.6	PAN	

EMERGENCY		
D9110	Z01.21	Palliative
D9230	Z98.812	Nitrous
D2940	K02.52	Sedative Fill
D0460	K04.99	Pulp Test

CARIES RISK		
D0601	Z98.812	Low
D0602	Z98.812	Medium
D0603	Z98.812	High

HYGIENE	ICD-10		
D1110	K05.00	Adult	14 yrs- up
D1120	K05.01	Child	0-13 yrs
D1208	K02.3	Fluoride	0-99 yrs

D9993	MOLAR SEALANTS	
1st Molar Sealants - Age 6-9		Yes/ No
D9994	SEALANTS NOT REQUIRED	
D1351	K02.3	Sealant 0-20 yrs

Tooth#:		
D0001	or	*Phase 1 Care Pending*
D0002		*ALL Phase 1 Care Complete*

PERIO			
D4341	K05.321	ScRP: UR, LR, UL, LL	
D4342	K05.321	Teeth:	
D4355	K05.10	Debridement	
D4910	K05.6	Maintenance	

Pre Medications	Yes / No
Sealants:	Yes / No
School Form:	Yes / No
Referral:	Yes / No

OS Perio Peds Endo Ortho

PSR:	/ / / /
Head Neck:	WNL / Note
Oral Cancer:	WNL / Note
Soft Tissue:	WNL / Note
Denture:	No / UP LP UD LD
ScRP:	No / UL LL UR LR
	Prophy / Debride / Maint
BP: /	Ortho: 1 2 3
	PEDS MS DS

End of Appt Survey:		
Did you have to wait longer than 20 minutes today to be seated?	Yes / No	D9981/2
Are you satisfied with your visit today?	Yes / No	D9983/4
Would you refer friends and family to Family Health Center?	Yes / No	D9985/6

Visit Type 2

FILLINGS (Silve	ICD-10		Tooth	Surface
D2140	K02.52	1 Surf		
D2150	K02.52	2 Surf		
D2160	K02.52	3 Surf		
D2161	K02.52	4 Surf		
Anterior WHITE Fillings				
D2330	K02.52	1 Surf		
D2331	K02.52	2 Surf		
D2332	K02.52	3 Surf		
D2335	K02.52	4 Surf		
Posterior WHITE Fillings				
D2391	K02.52	1 Surf		
D2392	K02.52	2 Surf		
D2393	K02.52	3 Surf		
D2394	K02.52	4 Surf		

DENTURES		
D5110	K08.101	Up Full Dent
D5120	K08.101	Low Full Dent
D5211	K08.401	Up PDent - Resin (Flipper)
D5212	K08.401	Low PDent - Resin (Flipper)
D5213	K08.401	Up PDent - Cast
D5214	K08.401	Low Pdent - Cast
D5421/2	Z97.2	Max/Man Partial Adjust
D5410/1	Z97.2	Max/Man FDenture Adjust

OTHER		
D9970	Z01.21	One Tooth Bleach Refill Syringe
D9972	Z01.21	Bleaching tray (per arch)
D9990	Z01.21	Non Billable Visit
D9991	Z01.21	Redo Visit
D9999	Z01.21	Fee for Service Impression

ROOT CANALS			Tooth
D3220	K04.1	Pulp	
D3310	K04.1	Ant.	
D3320	K04.1	Post.	
D3330	K04.1	Molar	
CROWNS			
D2750	K02.52	Crown	
D2920	Z98.812	Cement	
D2930	K02.52	SSC	
D2950	K02.52	BU	
EXTRACTIONS			
D7140	K03.81	Simple	
D7210	K03.81	Surg	
D7250	K08.3	Roots	
D7310	873.73	Alveoplasty w/ext	
D7321	873.73	Alveoplasty w/o ext	

Different ICD-10:	Yes / No
Other Code Per Doctor:	
Other Code Per Doctor:	

1 2 3 4 6 LHI HMO	
Doctor:	[Rizk]
Signature:	
Hygienist:	
Assistant:	
Data Entry:	

CC:	
NV:	

1	2	3	4 / A	5 / B	6 / C	7 / D	8 / E
32	31	30	29 / T	28 / S	27 / R	26 / Q	25 / P

9 / F	10 / G	11 / H	12 / I	13 / J	14	15	16
24 / O	23 / N	22 / M	21 / L	20 / K	19	18	17

Signature

I acknowledge the treatment plan explained by my healthcare provider above.

Family Health Services	**Title:** Patient Intake	ID #: FD1000 Effective: 02/01/2026 Page: 1
	PHONE: 419-502-2800 • FAX: 419-502-2821	

Family Health Services (FHS) is a Federally Qualified Health Center (FQHC), and we are required to ask the following questions. All information will remain confidential and will be used for reporting purposes only. Patient intake forms and consents will need to be updated annually.

LAST NAME:	FIRST NAME:	MI:
DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:	
STREET ADDRESS:		
CITY:	STATE:	ZIP:
CELL PHONE:	HOME PHONE:	WORK PHONE:
EMAIL ADDRESS:		
EMERGENCY CONTACT NAME:	EMERGENCY CONTACT PHONE:	RELATIONSHIP TO PATIENT:

ARE YOU A VETERAN: ☐ YES ☐ NO	**ARE YOU HOMELESS**: ☐ YES ☐ NO	**ARE YOU A RESIDENT OF PUBLIC HOUSING**: ☐ YES ☐ NO

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	**ARE YOU A SEASONAL AGRICULTURAL WORKER**: ☐ YES ☐ NO

SEX ASSIGNED AT BIRTH: ☐ MALE ☐ FEMALE ☐ UNKOWN	**PRONOUNS**: ☐ HE/HIM/HIS/HIS/HIMSELF ☐ SHE/HER/HER/HERS/HERSELF ☐ THEY/THEM/THEIR/THEIRS/THEMSELVES ☐ ZE/ZIR/ZIR/ZIRS/ZIRSELF ☐ XIE/HIR ("HERE")/HIR/HIRS/HIRSELF ☐ OTHER: _____	**SEXUAL ORIENTATION**: ☐ LESBIAN, GAY OR HOMOSEXUAL ☐ STRAIGHT OR HETEROSEXUAL ☐ BISEXUAL ☐ DO NOT KNOW ☐ CHOSE NOT TO DISCLOSE ☐ SOMETHING ELSE: _____

GENDER IDENTITY: ☐ MALE ☐ FEMALE ☐ FEMALE-TO-MALE (FTM)/TRANSGENDER MALE ☐ MALE-TO-FEMALE (MTF)/TRANSGENDER FEMALE ☐ GENDERQUEER, NEITHER EXCLUSIVELY MALE NOR FEMALE ☐ CHOSE NOT TO DISCLOSE ☐ OTHER: _____	**ANNUAL <u>HOUSEHOLD</u> INCOME & SIZE**: HOURLY RATE: _____ HOURS WORKED/WEEK: _____ MONTHLY INCOME: _____ ANNUAL INCOME: _____ TOTAL # OF PEOPLE IN YOUR HOUSEHOLD: _____

DO YOU HAVE A VEHICLE FOR TRANSPORTATION? ☐ YES ☐ NO	**DO YOU HAVE A LIVING WILL**? ☐ YES (PLEASE PROVIDE A COPY) ☐ NO	**DO YOU HAVE A HEALTHCARE POWER OF ATTORNEY**? ☐ YES (PLEASE PROVIDE A COPY) ☐ NO

MARITAL STATUS: ☐ DIVORCED ☐ MARRIED ☐ PARTNER ☐ SINGLE ☐ UNKNOWN ☐ WIDOWED ☐ LEGALLY SEPARATED	**PRIMARY LANGUAGE**: ☐ ENGLISH ☐ SPANISH ☐ OTHER: _____ IS A TRANSLATOR NEEDED: ☐ YES ☐ NO

RACE: (YOU MAY MARK MORE THAN ONE)	**ETHNICITY**:
☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN ☐ WHITE ☐ CHOSE NOT TO DISCLOSE ☐ OTHER: _____	☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ CHOSE NOT TO DISCLOSE ☐ OTHER: _____

WHAT IS YOUR PREFERRED PHARMACY?
NAME OF PHARMACY: CITY: PHONE NUMBER:

HOW DID YOU HEAR ABOUT FAMILY HEALTH SERVICES?

☐ FROM A FRIEND	☐ FROM A CURRENT PATIENT	☐ INSURANCE COMPANY
☐ COMMUNITY EVENT	☐ SOCIAL MEDIA (FACEBOOK, INSTAGRAM, ETC)	☐ HOSPITAL OR OTHER PROVIDER
☐ BILLBOARD	☐ NEWSPAPER	☐ RADIO
☐ CONTACTED BY FHS	☐ OTHER: _____	

IF THE PATIENT IS A MINOR, PLEASE FILL OUT THE SECTION BELOW WITH PARENT(S)/LEGAL GUARDIAN(S) INFORMATION

LAST NAME:	FIRST NAME:	MI:
DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:	
PHONE NUMBER:	RELATIONSHIP TO PATIENT:	
LAST NAME:	FIRST NAME:	MI:
DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:	
PHONE NUMBER:	RELATIONSHIP TO PATIENT:	

DOES THE PATIENT HAVE INSURANCE? ☐ YES ☐ NO
If YES, please complete the information below and present the patient's identification card (driver's license, state ID) as well as the insurance card(s). For minors, please present the parent's or legal guardian's identification card (driver's license, state ID).

If NO, a patient advocate will be in contact with you to discuss insurance enrollment, sliding fee scales and/or other payment options.

FOR SCHOOL BASED CLINICS: Copies of the identification cards and insurance cards can be made at the school or a picture (front and back of each card) can be emailed to clinicinfo@familyhs.org.

PRIMARY INSURANCE INFORMATION:

INSURANCE COMPANY:	POLICY HOLDER NAME:	
MAILING ADDRESS OF INSURANCE COMPANY:		
CITY:	STATE:	ZIP:
POLICY NUMBER:	GROUP NUMBER:	
EFFECTIVE DATE (MM/DD/YYYY):	EXPIRATION DATE (MM/DD/YYYY):	

SECONDARY INSURANCE INFORMATION: (IF APPLICABLE)

INSURANCE COMPANY:	POLICY HOLDER NAME:	
MAILING ADDRESS OF INSURANCE COMPANY:		
CITY:	STATE:	ZIP:
POLICY NUMBER:	GROUP NUMBER:	
EFFECTIVE DATE (MM/DD/YYYY):	EXPIRATION DATE (MM/DD/YYYY):	

GUARANTOR/RESPONSIBLE PARTY INFORMATION (IF NOT THE PATIENT)			
LAST NAME:		FIRST NAME:	MI:
DATE OF BIRTH (MM/DD/YYYY):		SOCIAL SECURITY NUMBER:	
STREET ADDRESS:			
CITY:	STATE:	ZIP:	
PHONE:	EMPLOYER:	RELATIONSHIP TO PATIENT:	
PATIENT BILL ADDRESS (IF ADDRESS IS DIFFERENT FROM PATIENT'S MAILING ADDRESS)			
STREET ADDRESS OR PO BOX:			
CITY:	STATE:	ZIP:	

By signing below, I am giving Family Health Services permission to bill my insurance for the services rendered. It is my responsibility to ensure Family Health Services has my most current insurance information. I also understand if there is a balance after the insurance processes the claim the person listed above as the guarantor/responsible party will receive a statement. I understand that Family Health Services offers a sliding fee scale to all patients. The sliding fee scales levels are posted within the clinics and copies are available upon request. I may at any time request an application for the sliding fee scale from Family Health Services.

SIGNATURE:	DATE:
PRINTED NAME:	

Family Health Services

Notice of Potential Dental Financial Responsibility

Patient Name: _____

Patient Date of Birth: _____

Dear Patient,

Some services or procedures at Family Health Services may not be covered 100% by your dental insurance, as plans can vary in what they consider medically necessary or eligible for payment.

There are varying factors that can exist from carrier to carrier; therefore, the office cannot guarantee any estimated charges. These variables include, but are not limited to:

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

By signing below, you acknowledge that:

1. Your policy and benefits are an agreement between you and the insurance company; therefore, you ultimately may be responsible for any charges not paid by said insurance.
2. The office has been informed, prior to your appointment, of any changes in your insurance coverage that may impact estimations.
3. Treatment Plan Estimates or Prior Authorizations are a good faith attempt to inform the cost of treatment based on known facts when the estimate was completed. As treatment progresses, any necessary changes in treatment could change the estimated cost.

If you have any questions about what may or may not be covered, please consult your insurance company and/or request assistance from a member of our team before receiving services.

Patient Signature: _____ **Date:** _____

Family Health Services	**Title:** No Show Policy	ID #: FD1004 Effective: 12/17/2025 Page: 1
	PHONE: 419-502-2800 • FAX: 419-502-2821	

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

Family Health Services (FHS) is committed to providing quality care to all our patients. FHS understands that things can happen to prevent patients from attending their scheduled appointments and/or arriving on time. To be considerate of FHS staff and other patients' time, please read the No Show Policy below to understand the guidelines and expectations when you are unable to make your appointment.

What is considered a "No Show" appointment:

- The patient does not call to cancel/reschedule their appointment and does not show up for the scheduled appointment time
- **For Primary Care and Behavioral Health Patients**: The patient arrives more than 15 minutes late for the scheduled appointment time and is consequently unable to be seen
- **For Dental Patients**: The patient arrives more than 10 minutes late for the scheduled appointment time and is consequently unable to be seen

How to avoid getting a "No Show" appointment:

- Confirm your appointment. FHS will attempt to contact you via an automated phone call one week prior to your scheduled appointment. The automated system will attempt to call up to five (5) times. Once you confirm your appointment, the automated system will stop calling you. You will also receive a text message reminder about your appointment the day before your appointment.
- Arrive early. When you schedule an office visit to one of the FHS locations, we would like you to arrive at our facility 15 minutes prior to your scheduled appointment time. This will allow you and our staff time to address any insurance and/or billing questions and/or complete any paperwork before the scheduled visit.
- Cancel/Reschedule your appointment. If you need to cancel/reschedule your appointment, we ask that you contact our office **at least two (2) hours prior** to your scheduled appointment.

What happens if I "No Show" my appointment:

- If you "no show" three (3) appointments within a six (6) month period, you may only be allowed to schedule same-day appointments, and they must be approved by the Clinical Site Manager.
- Three (3) "no show" appointments to a "New Patient" appointment will result in the patient not being able to be scheduled for services in that service line
- Recurrent "no show" appointments or continued non-compliant behavior to the No Show Policy will result in the patient being dismissed from FHS

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.**

Family Health Services	**Title:** HIPAA Acknowledgement Form	ID #: FD1003 Effective: 12/17/2025 Page: 1
	PHONE: 419-502-2800 • FAX: 419-502-2821	

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

Communication: FHS participates in one or more Health Information Exchanges. Health Information Exchanges are electronic networks used to securely provide access to the above-named patient's health records.

➡ _____ By initialing here, I consent to allow access to the above-named patient's health record through the Health Information Exchange.

➡ _____ By initialing here, I am authorizing FHS to leave a message on the above-named patient's answering machine or voicemail regarding scheduled appointments, pre-medication and instruction.

➡ I authorize the following person(s) to obtain medical information about the above-named patient. FHS is not responsible for the information provided if it is given to one/both people listed below.

☐ Check this box if you **do not** wish to have your information shared with anyone.

Name of Person Allowed to Receive Health Information:	Date of Birth (MM/DD/YYYY):
Phone Number:	Relationship to Above-Named Patient:
Name of Person Allowed to Receive Health Information:	Date of Birth (MM/DD/YYYY):
Phone Number:	Relationship to Above-Named Patient:

Use and Disclosure of Health Information: I have received the FHS Notice of Privacy Practices. If Federal Privacy Standards explain how FHS may use and disclose confidential health information that identifies the above-named patient.

By Signing Below I agree/consent to the following:

- I consent to the release of the above-named patient's health information and financial account information to all third-party payers and/or their agents that are identified by FHS, its billing agents, collection agents, attorneys or consultants. This includes other agents that represent FHS or aid FHS for the purposes of securing payment from all parties who are potentially liable for payment for the above-named patient's health care, including for substance abuse, psychiatric care or HIV, if applicable.

- If the above-named patient is a minor child, I authorize FHS to release all health information that is contained in the patient's record to the _____School District for treatment and otherwise needed for the above-named patient's safety and education at the sole direction of FHS. 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 to be completed. This authorization will automatically expire when **one** of the items below takes place:

    - HIPAA Acknowledgement Form will automatically expire annually
    - When FHS is no longer providing school-based health care services the School District mentioned above

- When the above-named patient is no longer a student at the School District mentioned above
- When I revoke this authorization.

- I can revoke my consent in writing at any time except to the extent that FHS has already relied on my consent by a written notice sent to:

  Family Health Services
  Attn: Administrator
  1912 Hayes Avenue
  Sandusky, OH 44870

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.**

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

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

Family Health Services	Notice of Nondiscrimination Policy	ID #: QA1003 Effective: 06/2025
	SUBJECT AREA: Quality	Page: 1

Family Health Services (FHS) complies with all applicable federal civil rights laws, including Section 1557 of the Affordable Care Act (Section 1557). FHS does not discriminate based on race, color, national origin (including language), age, disability, or sex (including gender identity). FHS does not discriminate based on health insurance, or coverage under that health insurance plan, and FHS will not discriminate if there is a need to use patient care decision support tools when making decisions regarding health care needs.

In compliance with Section 1557 and other federal civil rights laws, we provide individuals, when requested, with the following in a timely manner and free of charge:

- **Language assistance services.** FHS will provide language assistance services for individuals with limited English proficiency (including individuals' companions with limited English proficiency) to ensure meaningful access to our programs, activities, services, and other benefits. Language assistance services may include:
  - Electronic and written translated documents (available in at least the top 15 languages spoken in the state of Ohio)
  - Qualified interpreters

- **Appropriate auxiliary aids and services**. FHS will provide appropriate auxiliary aids and services for individuals with disabilities (including individuals' companions with disabilities) to ensure effective communication. Appropriate auxiliary aids and services may include:
  - Qualified interpreters, including American Sign Language interpreters
  - Video remote interpreting
  - Information in alternate formats (including but not limited to large print, recorded audio, and accessible electronic formats)

- **Reasonable modifications.** FHS will provide reasonable modifications for qualified individuals with disabilities, when necessary to ensure accessibility and equal opportunity to participate in our programs, activities, services, or other benefits.

To access our language assistance services, auxiliary aids and services, and for assistance in getting a reasonable modification, please discuss with a member of FHS's staff or your provider. For additional assistance, you may also contact FHS's 1557 Compliance Officer at 419-502-2800.

If you believe FHS has failed to provide these services or has discriminated in another way based on race, color, national origin (including language), sex (including gender identity), age, or disability, you can:

1. File a grievance with FHS's Risk Manager at 419-502-2800.
2. File a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:
   - *Online*: https://www.hhs.gov/ocr/index.html
   - *Phone:* 800-368-1019, TDD toll-free: 800-537-7697
   - *Email:* OCRMail@hhs.gov
   - *Via mail:* U.S. Department of Health & Human Services 200 Independence Avenue, S.W. – 509F, Washington, D.C. 20201