Family Health Services	**Title:** Patient Intake	ID #: FD1000 Effective: 07/20/2026 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 and are required to report on the information annually. You do have the right to refuse to report. All information will remain confidential and will be used for reporting purposes only. Patient intake forms and consents will need to be updated annually.

PATIENT INFORMATION:

LAST NAME:	FIRST NAME:	MI:	BIRTH DATE:	SOCIAL SECURITY #:

PREFERRED NAME:	PATIENT'S PRIMARY PHYSICIAN:

PATIENT BILLING ADDRESS (RESPONSIBLE PARTY):	CITY:	STATE:	ZIP:
PATIENT RESIDENCE (IF DIFFERENT):	**CITY:**	**STATE:**	**ZIP:**

WHICH CONTACT # DO YOU PREFER:
☐ Home: (_____)_____
☐ Cell: (_____)_____
☐ Work: ( )_____
EMAIL: _____

CAN WE SEND NOTIFICATIONS? (CHECK ALL THAT APPLY)
☐ Opt-Out ☐ Phone
☐ Text ☐ Voicemail
☐ E-Message

CONSENT TO SHARE DATA WITH EXTERNAL HEALTHCARE ENTITIES?
☐ Opt-In
☐ Opt-Out
☐ Emergency

BIRTH GENDER:
☐ Male ☐ Female

MARITAL STATUS:
☐ Single ☐ Married
☐ Widowed ☐ Divorced
☐ Separated ☐ Life Partner

PRIMARY LANGUAGE:
☐ English ☐ Spanish
☐ Chinese ☐ Japanese
☐ French ☐ Russian
☐ Arabic
☐ OTHER: _____

RACE:
☐ American Indian/Alaska Native
☐ Asian ☐ Asian Indian ☐ White/Caucasian
☐ Black/African American ☐ Samoan
☐ Native Hawaiian ☐ Hawaiian/Pacific Islander
☐ Chinese ☐ Japanese ☐ Korean
☐ Filipino ☐ Vietnamese ☐ More than one race
☐ Other Pacific Islander ☐ OTHER: _____

ETHNICITY:
☐ Non-Hispanic or Latino/Spanish Origin
☐ Hispanic or Latino/Spanish Origin
☐ Mexican/Mexican American/ Chicano
☐ Cuban
☐ Puerto Rican
☐ Decline to Answer

INSURANCE INFORMATION (Please present ALL insurance cards and picture ID to the front desk)

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	Policy #	Group #	Effective	Policy Holder	Relationship
Secondary Insurance	Policy #	Group #	Effective	Policy Holder	Relationship
Dental Insurance	Policy #	Group #	Effective	Policy Holder	Relationship

ADVANCED DIRECTIVE:

Do you have a living will? ☐ YES ☐ NO If yes, is it on file with your Primary Care Provider? ☐ YES ☐ NO

REQUIRED REPORTING

PERMANENT HOUSING:
☐ House/ Apt/ Mobile Home

Family Size: _____

Family Income:

$_____

☐ Refuse to Report

TEMPORARY/TRANSITIONAL HOUSING:
☐ Shelter
☐ Homeless/Street/Car
☐ Transitional
☐ Temporarily Living with Friends/Family
☐ Permanently Living with Friends/Family
☐ Other: _____

VETERAN:
☐ YES ☐ NO

MIGRANT AGRICULTURE WORKER:
☐ YES ☐ NO

SEASONAL AGRICULTURE WORKER:
☐ YES ☐ NO

PREFERRED PHARMACY:

_____

CITY:

_____

RESPONSIBLE PARTY:

LAST NAME:	FIRST NAME:	MI:	BIRTH DATE:	SOCIAL SECURITY #:	RELATIONSHIP:

EMPLOYER NAME:	EMPLOYER ADDRESS:	EMPLOYER PHONE:
	_____ _____	

IF PATIENT IS UNDER18 YEARS OLD:				
Is there custody involvement? ☐ YES ☐ NO **If yes, please see the front desk to complete the Authorization for the Treatment of Minors**				
Parent/Guardian #1		**Parent/Guardian #2**		
FIRST NAME:	**LAST NAME:**	**FIRST NAME:**	**LAST NAME:**	
PHONE NUMBER:		**PHONE NUMBER:**		
EMERGENCY CONTACT:				
LAST NAME:	**FIRST NAME:**	**BIRTH DATE:**	**PHONE NUMBER:**	**RELATIONSHIP:**

I understand that by signing this form, I agree to pay all balances pertaining to the services rendered. If I do not pay or should my account become delinquent, I realize that my information may be sent to a collection agency. I authorize my healthcare provider and/or entity authorized by my healthcare provider, including those using automated dialing systems, to communicate with me for any reason by any telephone number, email and mailing address provided. 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.

By signing below, I also acknowledge that the named patient has received a copy of the Notice of Privacy Practices and Patient Rights (a copy of the notice is included in your intake paperwork). This notice provides information about how we may use and disclose protected health information about you/the patient.

Signature of Patient/Responsible Party:	Date:	☐ Patient ☐ Parent ☐ Guardian
Patient Name/Responsible Party (PRINT):		

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	**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	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