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 INFORMATION**

| LAST NAME | FIRST NAME | MI |
|---|---|---|
| | | |

| PREFERRED NAME (NICKNAME) | GENDER |
|---|---|
| SOCIAL SECURITY NUMBER | ☐MALE ☐TRANSGENDER FEMALE |
| DATE OF BIRTH | ☐FEMALE ☐CHOOSE NOT TO DISCLOSE |
| | ☐TRANSGENDER MALE ☐OTHER |

**PATIENT BILLING/MAILING ADDRESS**

| STREET ADDRESS OR PO BOX | | |
|---|---|---|
| CITY | STATE | ZIP CODE |

**PATIENT CONTACT INFORMATION**

| MOBILE PHONE | ALTERNATIVE PHONE # | EMAIL |
|---|---|---|
| | | |

| PREFERRED METHOD FOR NOTIFICATION | MAY WE LEAVE A MESSAGE ON YOUR PHONE? |
|---|---|
| ☐ PHONE ☐ TEXT ☐ EMAIL ☐ AUTOMATED RECORDINGS | ☐ YES ☐ NO |

**PATIENT EMERGENCY CONTACT INFORMATION**

| NAME | ADDRESS | RELATIONSHIP | CONTACT PHONE # |
|---|---|---|---|
| | | | |

**PREFERRED PHARMACY**

| NAME | ADDRESS | PHONE NUMBER |
|---|---|---|
| | | |

**PARENTAL/GUARDIAN INFORMATION (IF PATIENT IS A MINOR)**

| NAME (LAST, FIRST, MI) | | | |
|---|---|---|---|
| SSN # | DATE OF BIRTH | RELATIONSHIP TO PATIENT | PHONE # |
| | | | |

**HOUSING STATUS**

☐ CURRENT RESIDENT OF PUBLIC HOUSING ☐ SHELTER ☐ OTHER _____
☐ HOMELESS ☐ TRANSITIONAL

OVER →

## PATIENT ADDITIONAL INFORMATION – FOR PUPOSES OF GRANT FUNDING ONLY

SEXUAL ORIENTATION –DO YOU THINK OF YOURSELF AS:

- ☐ STRAIGHT/HETEROSEXUAL
- ☐ LESBIAN
- ☐ GAY/HOMOSEXUAL
- ☐ BI-SEXUAL
- ☐ TRANSSEXUAL
- ☐ OTHER
- ☐ CHOOSE NOT TO DISCLOSE

ARE YOU OF HISPANIC OR LATINO ORIGN?

☐ YES ☐ NO

PRIMARY LANGUAGE

- ☐ ENGLISH
- ☐ SPANISH
- ☐ OTHER _____

INTERPRETER NEEDED?

☐ YES ☐ NO

RACE (You may mark more than one)

- ☐ AMERICAN INDIAN/ALASKAN NATIVE
- ☐ ASIAN
- ☐ BLACK/AFRICAN AMERICAN
- ☐ WHITE
- ☐ MORE THAN ONE RACE
- ☐ NATIVE HAWAIIAN
- ☐ OTHER PACIFIC ISLANDER
- ☐ OTHER NOT LISTED
- ☐ CHOOSE NOT TO DISCLOSE

ARE YOU A VETERAN OF THE ARMED FORCES?

☐ YES ☐ NO

HOUSEHOLD SIZE

☐ 1 ☐ 4 ☐ 7 ☐ 10
☐ 2 ☐ 5 ☐ 8 ☐ Other _____
☐ 3 ☐ 6 ☐ 9

ESTIMATED HOUSEHOLD INCOME $_____

☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ ANNUALLY

MARITAL STATUS

- ☐ SINGLE
- ☐ MARRIED
- ☐ DIVORCED
- ☐ WIDOW/WIDOWER
- ☐ LEGALLY SEPARATED
- ☐ LIFE PARTNER
- ☐ 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

In the last two years, have you or your family **moved to another area** to work in fields, orchards, greenhouses, farms, vineyards, packing houses, or with animals such as cattle, dairy, sheep, poultry, fish hatcheries, etc.? ☐ Yes ☐ No

## STRUCTURE INFORMATION

HOW DID YOU HEAR OF FAMILY HEALTH SERVICES?

- ☐ FROM A FRIEND OR PATIENT
- ☐ COMMUNITY EVENT
- ☐ SOCIAL MEDIA (FACEBOOK, TWITTER)
- ☐ HOSPITAL OR OTHER PROVIDER
- ☐ BILLBOARD
- ☐ NEWSPAPER
- ☐ OTHER _____

## GUARANTOR/RESPONSIBLE PARTY INFORMATION

FIRST NAME: _____ MI: _____ LAST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ DATE OF BIRTH: _____ SSN#: _____

RELATIONSHIP TO PATIENT: _____ EMPLOYER: _____

**PATIENT EMPLOYER**

NAME OF COMPANY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TYPE OF BUSINESS: _____ OCCUPATION: _____

COMPANY PHONE: _____

EMPLOYEMENT STATUS: ☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ DISABLED

**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: _____

**INSURANCE PAYMENT AUTHORIZATION AND RELEASE**

I hereby authorize my insurance benefits to be directly paid to Family Health Services and acknowledge that I am financially responsible for any unpaid balances. Payment is expected at time of service. I also authorize Family Health Services to release any medical information necessary to process claims for payment.

PATIENT/GUARANTOR SIGNATURE _____ DATE _____

**CONSENT FOR TREATMENT**

I the undersigned certify that the information contained on this form is correct to the best of my knowledge. I hereby authorize Family Health Services medical staff to administer treatments, protocols and/or medications/vaccines, which are deemed necessary.

PATIENT/GUARANTOR SIGNATURE _____

DATE _____

Thank you very much

Family Health Services

1912 Hayes Avenue
Sandusky, Ohio 44870
Phone: 419-502-2800
Fax: 419-502-2821

# Authorization to Release Medical Records

**PATIENT INFORMATION:**

NAME: _____ DOB: _____ MRN: _____

ADDRESS: _____ SS# _____

**PATIENT INFORMATION IS NEEDED FOR**:

| | | |
|---|---|---|
| Continuing Medical Care | Military | Social Security/Disability |
| Insurance | Personal Care | Other: _____ |
| Legal Purposes | School | _____ |

**INFORMATION TO BE RELEASED OR ACCESSED:**

| | | |
|---|---|---|
| History & Physical | Consultation Report | Emergency Room Record |
| Operative Reports | Discharge/Death Summary | Face Sheet |
| Lab/Path Reports | X-Ray Reports/Images | Other: _____ |

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

| | | |
|---|---|---|
| TO: | **Family Health Services** | **FROM: _____** |
| | **1912 Hayes Ave, Sandusky 44870** | **ADDRESS: _____** |
| | **(419)502-2800** | **PHONE: _____** |
| | **(419)502-2821** | **FAX: _____** |

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected. I understand that the specified drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS. 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.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ Signature _____

Patient or Legally Authorized Representative:

Printed Name: _____ Relationship: _____

# HIPAA Authorization Form

Family Health Service (FHS) has taken measures to protect all of our patients' private medical information. FHS will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices. Your protected health information will be used by FHS or disclosed to others for the purpose of the treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be sued or disclosed. You may review the notice prior to signing this consent. You may also request a copy of the Notice of Privacy Practices for your own records. See the receptionist to receive a copy. You may request a restriction on the used or disclosure of your protected health information. FHS may or may not agree to restrict the use or disclosure of your protected health information. If FHS agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the Federal Privacy Standards. You may revoke this consent to the use and disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. PCHC reserves the right to modify the Privacy Practices outlined in the notice.

Please see the receptionist with any questions prior to signing this authorization form.

I, _____, DOB _____ am authorizing the person/people listed below to obtain medical information about myself. I understand FHS is not responsible for the information provided as long as it is given to a person that I have listed below. Date of Birth must be provided so that our office can verify that we are speaking to the correct person.

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

I have reviewed this consent form & give my permission to FHS to Use & Disclose my health information in accordance of the Federal Privacy Standards.

Patients Signature: _____ Date: _____

If guardian, relationship to patient: _____

Over ⟶

I, _____, do not authorize FHS to release any of my protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

Patient's Signature: _____ Date: _____

If guardian, relationship to patient: _____

I, _____, do authorize this emergency contact

_____ to be called only in case of emergency. I understand none of my private information will be released.

Relationship:_____ Phone:_____

## PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

May Family Health Services (FHS) leave a message on your answering machine or voicemail regarding the following: Scheduled appointments, premedication and instruction appointments **YES NO**

Assignment of Insurance Benefits, Release of Information and Authorization of Treatment. I, the undersigned authorize my insurance benefits to be paid directly to the provider of Family Health Services for services rendered. I understand that I am ultimately financially responsible for any balance due for approved and covered charges not paid by insurance. I hereby authorize Promise FHS to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claim submissions. I understand that payment is expected at the time services are rendered. A copy of this is as valid as the original.

Signature: _____

Date: _____


**PATIENT PRIVACY NOTICE**
**Revised: June 13, 2016**

**This notice describes how clinical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

## PATIENT RIGHTS

You have the right to:

- Get a copy of your paper or electronic health record
- Correct your paper or electronic health record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

## PATIENT CHOICES

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide behavioral health care
- Market our services and sell your information
- Raise funds

### HEALTH CENTER USES AND DISCLOSURES

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

**PATIENT RIGHTS**

***When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.***

Get an electronic or paper copy of your health record

• You can ask to see or get an electronic or paper copy of your health record and other health information we have about you. Ask us how to do this.

• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. Ask us to correct your health record

• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

• We will say "yes" to all reasonable requests. Ask us to limit what we use or share

• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. Get a list of those with whom we've shared information

• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. Get a copy of this privacy notice

• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. Choose someone to act for you • If you have given someone clinical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

• We will make sure the person has this authority and can act for you before we take any action. File a complaint if you feel your rights are violated

• You can complain if you feel we have violated your rights by contacting Stacy Honaker, FHS's Privacy Officer by sending a letter to 1912 Hayes Avenue Sandusky, Ohio 44870, calling 419-502-2800, or emailing honakers@familyhealthservices.biz.

• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1- 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

• We will not retaliate against you for filing a complaint.

## PATIENT CHOICES

***For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.***

In these cases, you have both the right and choice to tell us to

• Share information with your family, close friends, or others involved in your care

• Share information in a disaster relief situation

• Include your information in a hospital directory If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases we never share your information unless you give us written permission

• Marketing purposes

• Sale of your information

• Most sharing of psychotherapy notes In the case of fundraising

• We may contact you for fundraising efforts, but you can tell us not to contact you again.

## HEALTH CENTER USES AND DISCLOSURES

***How do we typically use or share your health information? We typically use or share your health information in the following ways.***

Treat you

We can use your health information and share it with other professionals who are treating you.

o Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

• We can use and share your health information to run our practice, improve your care, and contact you when necessary.

o Example: We use health information about you to manage your treatment and services.

Bill for your services

• We can use and share your health information to bill and get payment from health plans or other entities.

o Examples: We give information about you to your health insurance plan so it will pay for your services.

## How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

## Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

## Do research

We can use or share your information for health research.

## Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

## Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

## Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

## Address workers' compensation, law enforcement, and other government

requests. We can use or share health information about you

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

## Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## Health Center Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

**Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site