1912 Hayes Avenue
Sandusky, Ohio 44870
419-502-2800

Family Health Services of Erie County
An Independent Healthcare Provider

ADULT PATIENT INFORMATION

Patient Name _____ Birth date _____ Race: _____ Sex: M _____ F _____
(for statistical purposes only)

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email Address _____

Social Security # _____ Marital Status: Single _____ Married _____ Divorced _____ Widow _____

Employer Name _____ Address _____ Phone _____

SPOUSE / PARENT / FOSTER / GUARDIAN INFORMATION (please circle one)

Name _____ Birth date _____

Address _____ City _____ State _____ Zip _____

Phone _____ Social Security # _____

Employer _____ Phone _____

Work Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT

Name _____ Phone _____

PATIENT INSURANCE COVERAGE

Primary Insurance _____ Group/ID # _____

Secondary Insurance _____ Group/ID # _____

DO YOU HAVE MEDICAID OR MEDICARE COVERAGE? Yes____ No ____ (If yes, please give # below)

Medicaid # _____ Medicare # _____

ARE YOU SELF-PAY? Yes _____ No _____ (A sliding fee scale is required for all self-pay patients)

I hereby authorize the release of any medical information necessary for the processing of insurance. I also authorize insurance benefits to be paid directly to Family Health Services of Erie County. I understand that if my insurance does not pay, I am responsible for payment of services provided.

Signature _____ Date _____

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I hereby authorize Family Health Services of Erie County to examine, treat, immunize and prescribe medication. I also consent to examination by resident physicians, interns and medical students, under the supervision of the Family Health Services of Erie County physicians. I will be responsible for payment of fees (if any) for the services I receive.

I hereby acknowledge that on the date listed below I received the Notice of Privacy Practices of Family Health Services of Erie County which sets forth the ways in which my protected health information for treatment, payment and health care operations.

I understand that Family Health Services of Erie County may contact me regarding treatment and services. The clinic will accommodate reasonable requests as to how I will receive the information as follows:

_____ Telephone: O.K. to leave a message with whomever answers my phone or on an answering machine or voice mail.

_____ Written communications: O.K. to mail to my address

_____ Restrictions: _____

_____ _____
Printed Name of Client Address

_____ _____
Signature of Client Phone Number

_____ _____
Signature of Parent/Guardian Address (if different from client)

_____ _____
Relationship to Client Address (if different from client)

_____ _____
Witness Date

Rev. 1/2015 Provider #: _____

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AUTHORIZATION FORM FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION:

PATIENT NAME:_____
LAST FIRST MI MAIDEN OR OTHER

_____ _____ _____
DOB SSN MEDICAL RECORD #

_____ _____ _____
ADDRESS CITY/STATE ZIP CODE

INFORMATION RELEASED FROM:

_____
NAME

_____
ADDRESS

_____
CITY/STATE/ZIP

INFORMATION RELEASED TO:

_____
NAME

_____
ADDRESS

_____
CITY/STATE/ZIP

INFORMATION TO BE RELEASED OR INSPECTED: (Check all applicable categories.)

_____ Entire Chart/Record, including, but not limited to, all of the following:

____Immunizations
____Discharge Summary
____History & Physical
____Operative Reports
____Emergency Room Reports
____Pharmacy/Prescription
____Emergency Transport Reports
____X-ray and Other Radiology Reports
____Laboratory Reports
____HIV Related Information
____Nursing Notes
____Doctor's Orders and Progress Notes
____Copies of Reports Originating From Other Providers
____PT, OT, and/or Speech Therapy Notes
____Rehab Clinic Reports
____Mental Health/Alcohol or Drug Abuse Treatment, HIV, and/or AIDS-related Treatment
____Workers' Compensation
____Billing and Patient Account Records
____Social Services Reports and/or Evaluations

____Other:_____

REASON FOR DISCLOSURE: _____

This authorization will remain in effect for eight (8) months or until _____ and will be effective for medical records generated up to the date of the signature. I understand that:

1. I have a right to revoke this authorization, except to the extent that information has already been released in response to this authorization.
2. I may inspect and receive a copy of the disclosed information upon payment of a reasonable fee.

A FAX copy/photocopy of this authorization shall be considered as valid as the original.

_____ _____
Signature of Patient Signature of Parent/Guardian/Authorized Person

_____ _____
Date Date
Reason Patient Unable to Sign: __Minor__Incompetent__Deceased

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NO SHOW AND TERMINATION POLICY
PATIENT INFORMATION

A. **Termination Policy**:
   1. Every patient that is terminated from the care at FHSEC will receive a registered letter from the physician or designee stating the reason for termination.
   2. Once an individual physician has terminated the care of a FHSEC patient, no physician within the FHSEC system will provide care for that patient.
   3. If the patient feels the termination of care is unjust, then he/she can, during the 30-day period, make an appointment to discuss the extenuating circumstances with the CEO.
   4. If the patient is under 18 years of age, the social worker will attempt to contact the guardian.
   5. The patient's file will be documented to verify that all measures were taken to fully inform and educate the patient about the importance of complying with the physician's recommendations and the medical protocol before termination.
   6. The following are considered reasons to terminate a patient from Family Health Services of Erie County (FHSEC):
      a. Misuse/abuse of prescriptions and medications
      b. An individual who fails to show for their first appointment without notification or rescheduling
      c. The physician determines he/she cannot provide continued, effective care.
      d. Threat of legal action against FHSEC physicians and employees.
      e. Leaving the hospital against medical advice will necessitate immediate discharge from FHSEC
      f. Chronically not showing for appointments
      g. Failure of patient to comply with the physician's orders regarding the patient's care if that decision prevents the physician from providing adequate medical care
      h. Discharge will be immediate for a threatening behavior or any implication of harm to any FHSEC staff member

B. **No-Show Policy**:
   1. Three (3) missed appointments without cancelling is considered chronically no show.
   2. On the first and second no-show appointments, a patient will receive a no-show letter. These letters will be signed and/or initialed by the CEO or physician that was scheduled to see that patient. An appeal form will be included with the letters which will give the patient 14 days from the postmark date to file an appeal. On the third no-show appointment, a patient may be terminated from the practice.
   3. Once a patient is discharged from the practice for no-shows, the patient has to wait outside the practice for one (1) year before readmission to the practice.

Every effort will be made to provide ongoing health care to all patients at FHSEC. This medical practice does not discriminate in providing care to a patient due to race, color, sex, religion, national origin, age, handicap, or any other factors prohibited by law.

I have read and agree to abide by the above policy:

( )

_____ _____
Signature and (Printed Name) Date