FAMILY Health

Welcome to Family Health Services of Darke County! We are pleased to have you as a new patient. To ensure that your visit runs smoothly, please arrive 15 minutes before your scheduled appointment time.

Please bring the following documents:

- Your driver's license or state ID card
- Insurance card(s)
- Prescription card(s)
- Completed new patient packet
- A list of your current medications

Thank you for choosing Family Health, and we look forward to seeing you soon!

Authorization to Release Medical Information

❑ **To Family Health**
5735 Meeker Road Greenville, OH 45331
(937)548-9680 Fax# (937)548-2087

❑ **From Family Health** (Address Above)

Physician/Practice/Organization Authorized to Use or Disclose Information

_____
Name of physician/practice/organization

_____
Address

_____
City/State/Zip Phone #: Fax #:

Patient Information

_____
Name of Patient (Print or Type)

_____
Street State City Zip

_____
DOB SS#

Phone Number (_____) _____

Information to be Used or Disclosed:

The information covered by this authorization includes

- ❑ All records
- ❑ Progress Notes
- ❑ Laboratory Reports
- ❑ Radiology Reports
- ❑ Operative Reports
- ❑ Other_____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information related to:

- ❑ Substance abuse (including alcohol or drug abuse)
- ❑ Therapy Notes
- ❑ HIV related information (including AIDS related testing)

X_____ _____
Signature of Patient or Legal Guardian Date

THIS INFORMATION IS TO BE USED FOR THE PURPOSE OF:

- ❑ Permanently transferring all records to another provider
- ❑ For Referral Only
- ❑ Workers' Compensation
- ❑ Second Opinion
- ❑ Legal
- ❑ Insurance
- ❑ Patient's Request
- ❑ Continuity of Care
- ❑ Probation
- ❑ Behavioral Health And Wellness School Based Counseling
- ❑ Other_____

This authorization is effective for one year __/___/____ or specific date less than 1-year __/__/_____ unless revoked or terminated earlier by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Family Health.

Potential for Re-Disclosure

The person or organization to which it is sent may disclose information that is disclosed under this authorization again. It may not be possible to ensure your right to the protection of the privacy of this information once Family Health discloses it to another party. The potential for re-disclosure does not apply to information related to alcohol abuse or drug abuse diagnosis and/or treatment.

Rights of the Individual

- You may inspect or copy the information used or disclosed under this authorization.
- You may refuse to sign this authorization.

_____ _____ _____ _____
Signature of Patient or Patient Representative: **Date:** **Witness:** **Date:**

Relationship to patient (Print Name/Relationship): _____

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65. You are not protected under this rule if you are involved in a crime on the premises of the part 2 program or against personnel of the part 2 program, or if reports of suspected child abuse and neglect are made to appropriate state or local authorities.

Today's Date: Month / Day / Year

FAMILY HEALTH SERVICES
PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name	First Name	MI	Nickname	Birth Date	Social Security #

Patient's Primary Physician:

Patient Billing Address (Responsible Party)	City	State	Zip
Patient Residence (If different)	**City**	**State**	**Zip**

Which Contact # You Prefer:
☐ Home Phone# (____)_____
☐ Cell Phone # (____)_____
☐ Work Phone # (____)_____
EMAIL:
_____

Can we send notifications?
☑ **All that Apply:**
☐ Opt Out
☐ Phone ☐ Text
☐Voicemail ☐eMessage

Consent to share data with external healthcare entities:
☐ Opt In
☐ Opt Out
☐ Emergency

Birth Gender:
☐ Female
☐ Male

Marital Status:
☐ Single
☐ Married
☐ Widowed
☐ Divorced
☐ Separated
☐ Life Partner

Gender Identity:
☐ Female
☐ Male
☐ Female-to-Male (FTM) Transgender Male
☐ Male-to Female, (MTF) Transgender Female
☐ Neither exclusively Male or Female (Genderqueer)
☐ Choose not to Disclose ☐ Other

Sexual Orientation:
☐ Straight, Heterosexual
☐ Bisexual
☐ Lesbian, Gay, Homosexual
☐ Don't Know
☐ Choose not to Disclose
☐ Other

Preferred Language:
☐English ☐ Spanish
☐Chinese ☐ Japanese
☐French ☐ Russian
☐Arabic
☐Other: _____

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

Ethnicity:
☐ Hispanic or Latino/Spanish Origin
☐ Non-Hispanic or Latino/Or Spanish Origin
☐Mexican/Mexican American/Chicano
☐Cuban
☐Puerto Rican
☐ Decline

INSURANCE INFORMATION (Please present ALL Insurance Cards and Picture ID to the receptionist):

Primary Insurance	Policy #	Group #	Effective	Co-Pay $	Policy Holder	Relationship
Secondary Insurance	Policy #	Group #	Effective	Co-Pay $	Policy Holder	Relationship
Dental Insurance	Policy #	Group #	Effective	Co-Pay $	Policy Holder	Relationship
Vision Insurance	Policy #	Group #	Effective	Co-Pay $	Policy Holder	Relationship

ADVANCED DIRECTIVE:

Do you have a living will? ☐ Yes ☐ No Is it on file with your Primary Care Provider? ☐ Yes ☐ No

REQUIRED REPORTING

Permanent Housing:
☐ House/Apt/Mobile Home

Family Size: _____

Temporary/Transitional Housing:
☐ Shelter
☐ Homeless/Street
☐ Transitional
☐ Temporarily Living with Friends/Family
☐ Permanently Living with Friends/Family
☐ Other: _____

Veteran:
☐ Yes
☐ No

Migrant Agriculture Worker:
☐ Yes
☐ No

Seasonal Agriculture Worker: (NON OH/IN Residents)
☐ Yes
☐ No

Family Income:
☐ < $10,000
☐ $10 - $20,000
☐ $20 - $40,000
☐ $40 - $60,000
☐ $60,000 <

☐ **Refuse to report**

Preferred Pharmacy:
_____

Family Health is required to report the following information annually. You do have the right to refuse to report.

Revised 05/03/23

☐ Kiosk Check-In

FAMILY HEALTH SERVICES
PATIENT REGISTRATION FORM

RESPONSIBLE PARTY:					
Last Name	First Name	MI	Social Security #	Birth Date	Relationship

Employer Name:	Employer Address:_____	Employer Phone: ( )

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.

X_____ _____

Patient Name/Responsible Party (Print) **Signature of Patient/Responsible Party** **Date of Signature**

☐ Patient ☐Parent ☐Guardian

IF PATIENT IS UNDER 18 YEARS OLD:

Is there custody involvement? ☐ Yes ☐ No *If yes please see front desk for Acknowledgement of Child Custody Matters

Parent/Guardian #1		Parent/Guardian #2	
First Name	Last Name	First Name	Last Name
Phone:		Phone:	

EMERGENCY CONTACT:			
Name	Relationship	DOB	Phone

Health Insurance Portability and Accountability (HIPAA)
Accountability for Release of Health Information/Notice of Privacy Practices

Authorization for Release of Health Information

I authorize that the following people may have access to my health information. I understand that the physician must have looked at and signed off the information before it will be copied and given to the authorized person(s) named below.

Name	Relationship	Phone ( )
Name	Relationship	Phone ( )
Name	Relationship	Phone ( )
Name	Relationship	Phone ( )

I wish to be contacted in the following manner (check all that apply):

☐Home Telephone: (_____)_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐Work Telephone: (_____)_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work address
- ☐ O.K. to fax to this number

☐Other: _____

Notice of Privacy Practices

Acknowledgment of Receipt Patient's Name (PRINTED)

Family Health Notice of Privacy Practices provides information about how we may use and disclose protected health information about you, the patient.

I, the patient (or Patient Representative on behalf of the patient) acknowledge that I have seen or received a copy of the Family Health *Notice of Privacy Practices.*

_____ _____

Patient's Name (PRINTED) **Relationship to Patient**

X_____ _____

Patient Signature or Patient's Representative **Date**

[ ] Check here to opt out of receiving notifications regarding fund-raising efforts Family Health may undertake.

Adult Comprehensive Patient History

☐ New Patient ☐ Established Patient

Today's Date: _____

Name: _____ D.O.B _____ Age: _____ Date: _____

Past History: *Check all that apply*

- ☐ Acid reflux
- ☐ Alcohol or Drug problems
- ☐ Allergy problems
- ☐ Anemia
- ☐ Artery problems
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bleeding problems
- ☐ Blood clots
- ☐ Cancer
- ☐ Colitis
- ☐ Crohn's disease
- ☐ Depression, Anxiety
- ☐ Diabetes
- ☐ Emphysema
  - ☐ Other lung disease
- ☐ Esophagitis, ulcers
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart disease
- ☐ Heart valve problems
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irritable bowel
- ☐ Kidney stones
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Recurrent skin infections
- ☐ Recurrent UTI
- ☐ Seizures
- ☐ Sexually transmitted infections
- ☐ Stroke
- ☐ Thyroid diseases
- ☐ Vein problems

☐ Other diseases not listed _____

☐ Explain any of the above if necessary _____

_____

_____

☐ Hospitalizations _____

_____

Surgery/Procedures: **[Date]** **[Date]** **[Date]**

- ☐ Appendix
- ☐ Bladder suspension
- ☐ Blood vessel surgery
  - ☐ Arteries
  - ☐ Veins
- ☐ Dental surgery
- ☐ Eye surgery
- ☐ Gallbladder
- ☐ Heart surgery
  - ☐ Bypass
  - ☐ Heart valve surgery
  - ☐ Angioplasty (balloon)
  - ☐ Stents
- ☐ Hysterectomy
  - ☐ Complete
  - ☐ Partial (ovaries preserved)
- ☐ Joint Replacement
- ☐ Orthopedic surgery
- ☐ Prostate surgery
- ☐ Tonsils and/or adenoids
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Colon Surgery

☐ Other surgery not listed above _____

☐ Significant injuries _____

Medication List:

Name of medication, vitamin, OTC supplements or herbal medicine	Dosage	Times/day	Disease or Reason	Prescriber of Medication

Name:_____

Allergies/ Intolerance:

Medication	Describe Reaction	Approximate Date of Reaction
1		
2		
3		
4		
5		

Medical Specialists:

Specialty Type:	**Name of Specialty Provider:**
Behavioral Health Clinician:	
Cardiologist:	
Dermatologist:	
Endocrinologist:	
ENT:	
Gastroenterologist:	
Hematologist:	
Home Health Agency:	
Medical Supply Company:	
Nephrologist:	
Neurologist:	
Hematology/Oncologist:	
OB/GYN:	
Ophthalmologist:	
Orthopedic:	
Pain Management:	
Podiatrist:	
Psychiatrist:	
Pulmonologist:	
Rheumatologist:	
Surgeon:	
Urologist:	
Veteran's Affairs Medical:	
Other:	

Name:_____

Family History:

Family Member	Year of Birth/ Age	Living	Deceased	Diseases
Father				
Mother				
Brother(s) #				
Sisters(s) #				

Diseases in the family: Check all that apply

☐ Arthritis ☐ Addiction problems ☐ Bleeding Problems

Cancer(s) ☐ Colon ☐ Breast ☐ Prostate ☐ Other type of cancer(s) _____

☐ Depression/Anxiety ☐ Diabetes ☐ Heart disease ☐ High blood pressure

☐ High cholesterol ☐ Kidney disease ☐ Liver disease ☐ Mental illness

☐ Other

☐ Details / Other _____

Social History:

Do you smoke? ☐ Currently ☐ Past ☐ Never ___ packs/day for ___ years. Tobacco other than smoking? ☐ NO ☐ YES

Have you used drugs other than those for medical reasons in the past 12 months? ☐ NO ☐ YES

Did you have a drink containing alcohol in the past year? ☐ NO ☐ YES

Occupation _____ Any known occupational exposures? _____

Preventative Care:

Date of last Colon and Rectal Cancer screening: _____ Test type: Colonoscopy/ Cologuard/ stool test/ other

If applicable, location of procedure:_____ Recommended next recheck: _____

Date of last eye exam: _____ Have you had bone density (DEXA) exam? ☐ NO ☐ YES Date: _____

Immunizations: ☐ See attached copy of my immunization record (if attached do not complete immunization chart below)

Immunizations:	Date of recent vaccine	**Immunizations:**	Date of recent vaccine
Tetanus		Hepatitis A	
Influenza		Hepatitis B	
Pneumonia		Shingles	
Whooping cough		HPV	
Covid-19			

For our FEMALE patients only:

Do you have a Gynecologist? ☐ Yes ☐ No If yes, Gynecologist name: _____

Date of last PAP test _____ Date of last mammogram _____Do you do self-breast exams? ☐ Yes ☐ No

Date of last Abnormal Pap Smear? _____ ☐ Not Applicable

Have you gone through menopause? ☐ Yes ☐ No

Birth Control or hormone therapy? ☐ Yes ☐ No If yes, type_____

Menstrual or period problems: ☐ Irregular ☐ Heavy ☐ Change in frequency

Number of pregnancies _____ #Llive births _____#Stillbirth(s)_____ # Miscarriages _____# of abortions

#Vaginal birth(s) _____ #C-section(s) _____

Can you think of anything else that you think we should know about your health and lifestyle that is not listed here?

_____

Review of Systems: **Name:**_____

Please indicate any problems in the following areas that are bothering you. If your planned visit is for a Preventative Physical, please be aware that another office visit may need to be scheduled to address new specific issues in appropriate detail.

Check all that apply:					
Constitutional:	☐ Fever	☐ Chills/Sweats	☐ Weight gain / Loss	☐ Fatigue	☐ Weakness
	☐ Poor appetite	☐ Appetite change			
Eyes:	☐ Blurred vision	☐ Double vision	☐ Eye pain		
Ears:	☐ Ear pain	☐ Decreased hearing	☐ Dizziness (light headed, room spinning)	☐ Ringing	
Nose:	☐ Congestion	☐ Sinusitis	☐ Difficulty breathing through nose	☐ Frequent nose bleeds	
Throat:	☐ Sore throat	☐ Sensation of fullness	☐ Difficulty swallowing		
Neck:	☐ Neck pain	☐ Fullness or lumps			
Pulmonary:	☐ Cough	☐ Shortness of Breath	☐ Asthma		
Cardiovascular:	☐ Chest discomfort (pain, pressure, fullness squeezing) with exertion or exercise			☐ Heart palpitations	
	☐ Heart racing	☐ Shortness of breath while lying down or with exertion (out of proportion to activity)			
	☐ Swelling of legs	☐ Fainting			
GI:	☐ Nausea	☐ Vomiting	☐ Abdominal		
	☐ Heartburn	☐ Sudden fullness	☐ pain		
	☐ Diarrhea	☐ Constipation	☐ Hemorrhoids		
			Blood in stool	☐ Change in frequency of stools	
Genitourinary:	☐ Pain with urination	☐ Increased frequency of urination		☐ Frequent nighttime urination	
	☐ Blood in urine	☐ Sexual problems	☐ Difficulty with erections	☐ Vaginal pain	
	☐ Vaginal discharge	☐ Slow stream/dribbling	☐ Incontinence		
Musculoskeletal:	☐ Joint pains	☐ Muscle weakness	☐ Muscle pain	☐ Back pain	
Skin:	☐ Rash	☐ Sores	☐ Moles that are changing	☐ Itching	☐ Dry skin
	☐ Eczema	☐ Have seen dermatologist in past year	Dermatologist's name: _____		
Neurological:	☐ Headaches	☐ Numbness/Tingling	☐ Weakness	☐ Speech abnormalities	
	☐ Fainting	☐ Memory Problems	☐ Imbalance/vertigo	☐ Headaches	☐ Tremors
Psychological:	☐ Anxiety	☐ Eating disorder	☐ Obsessive behavior	☐ Depression	☐ Unusual fears
	☐ Mood swings	☐ Crying spells	☐ Lack of motivation	☐ Drug dependence	
	☐ Alcohol problems	☐ Insomnia	☐ Panic attacks	☐ Anger/Rage	

Do you have Advanced Directives (Living Will, Durable Medical Power of Attorney)? ☐ Yes ☐ NO

Do you have a DNR?

☐ NO, I wish to be a FULL CODE

☐ Yes, DNR Comfort Care — Arrest (Providers will treat patient as any other without a DNR order until the point of cardiac or respiratory arrest at which point all interventions will cease and the DNR Comfort Care protocol will be implemented)

☐ Yes, DNR Comfort Care

If yes, please bring a copy to the office for your file.

Reviewed with patient on _____ Signature _____

Date Complete/Updated: _____

PRAPARE

Patient Name: _____ Date of Birth: _____

Money & Resources

What is your current housing situation?

☐ I have housing
☐ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, or in a park)
☐ I choose not to answer this question

Are you worried about losing your housing?

☐ Yes
☐ No
☐ I choose not to answer this question

What is the highest level of school that you have finished?

☐ Less than a high school degree
☐ High School diploma or GED
☐ More than high school
☐ I choose not to answer this question

What is your current work situation?

☐ Unemployed and seeking work
☐ Part time or temporary work
☐ Full time work
☐ Otherwise unemployed but not seeing work (ex. student, retired, disabled, unpaid primary care giver)
☐ I choose not to answer this question

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.

☐ Food
☐ Clothing
☐ Utilities
☐ Child care
☐ Medicine or any health care (medical, dental, mental health or vision)
☐ Phone
☐ Other _____
☐ I do not have problems meeting my needs
☐ I choose not to answer this question

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

☐ Yes, it has kept me from medical appointments or form getting my medications
☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things needed for living
☐ No
☐ I choose not to answer this question

Revised 08.10.2023_cw

Date Complete/Updated: _____

Social and Emotional Health

How often do you see or talk to people that you care about and feel close to?

For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

☐ Less than once a week
☐ 1 or 2 times a week
☐ 3 to 5 times a week
☐ More than 5 times a week
☐ I choose not to answer this question

How stressed are you?

Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled

☐ Not at all
☐ A little bit
☐ Somewhat
☐ Quite a bit
☐ Very much
☐ I choose not to answer this question

In the past year, have you been afraid of your partner or ex-partner or someone in your hourshold?

☐ Yes
☐ No
☐Unsure
☐ I have not had a partner in the past year
☐ I choose not to answer this question

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? (Nurses: Document under HPI> General> SILS)

☐ 1 (never)
☐ 2 (rarely)
☐ 3 (sometimes)
☐ 4 (often)
☐ 5 (all of the time)

Would you like staff to contact you for help with any of these needs? (Staff: If Yes, Send Referral to CHW)

☐ Yes
☐ No

FAMILY Health
Building healthy lives Together

Patient Informed Consent

INFO FOR PATIENT: Collaborative drug therapy management is a team approach to help patients age 18 and up use medicine in a safe and effective way to control long term medical problems. Our program also helps patients control their blood sugars and prevent illnesses through getting vaccines. Once referred to the program by your primary care physician, you will meet with the pharmacist to learn more, provide consent, and develop a treatment plan. You will follow up as needed to monitor your progress and make adjustments to the plan.

Benefits: The pharmacist will review your medical history and make an individualized treatment plan. Pharmacists are experts in dispensing medication and monitoring patients to ensure medications are safe and effective.

Costs/risks: You will need to be available to actively participate in providing history, developing a plan, following the plan, and returning for monitoring with the pharmacist and your PCP.

1. I understand that, as a patient at Family Health, I am required to be at all clinic appointments
2. I am able to travel to the clinic for my appointments or be reached by phone.
3. I will make personal goals regarding my care, and actively participate in creating and following the plan of care. I will ask questions when I don't understand something.
4. I am willing to follow instructions with my medications, proper diet, and the drugs
5. I am taking (prescription, over-the-counter and herbal/vitamin products) and will call the clinic if anything changes.
6. I have access to a telephone and can be reached by telephone if necessary.
7. I agree to have the clinical pharmacist participate in the management of my disease state(s), and may leave the program at any time.
8. I agree to provide another person's information, whom I authorize Family Health Services to contact and give information to regarding my medication therapy.
9. I know that I can stop participating in the program at any time by telling my primary care physician or pharmacist.

_____

Patient Name Date of birth

_____

Patient Signature Date

_____

Witness Signature Date

FAMILY Health
Building healthy lives Together

INFORMED CONSENT FOR TELEHEALTH

This Informed Consent for Telehealth contains important information focusing on providing healthcare services using the phone or the Internet. Please read this carefully and let me know if you have any questions.

Benefits and Risks of Telehealth

Telehealth refers to providing remote services using telecommunications technologies, such as video conferencing or telephone within Family Health's scope of services such as medical, dental, and behavioral health. One of the benefits of telehealth is that the patient and clinician can engage in services without being in the same physical location. This can be helpful particularly during the Coronavirus (COVID-19) pandemic in ensuring continuity of care as the patient and clinician likely are in different locations or are otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telehealth, however, requires technical competence on both our parts to be helpful. Although there are benefits of telehealth, there are some differences between in-person treatment and telehealth, as well as some risks. For example:

- Risks to confidentiality. As telehealth sessions take place outside of Family Health Services, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end, I will take reasonable steps to ensure your privacy. It is important; however, for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telehealth. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Medical emergency/ Crisis management and intervention. Usually, I will not engage in telehealth with clients who are currently in a crisis situation requiring high levels of support and intervention.

Electronic Communications

You may have to have certain computer or cell phone systems to use telehealth services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telehealth.

Treatment is most effective when clinical discussions occur at your regularly scheduled appointments. But if an urgent issue arises, you should feel free to attempt to reach me by calling the office or the after-hours provider on call. If you are unable to reach me and feel that you cannot wait for me to return your call, and if you need immediate attention, go to the nearest emergency room or call 911.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of telehealth services. The nature of electronic communications technologies, however, is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telehealth sessions and having passwords to protect the device you use for telehealth).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Notice of Privacy Practices still apply in telehealth. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telehealth

I will let you know if I decide that telehealth is no longer the most appropriate form of treatment for you. If you decide telehealth is not optimal for you, it is important to let me know. We will discuss options for other types of appointments.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telehealth than in traditional in-person treatment. To address some of these difficulties, we will create an emergency plan before engaging in telehealth services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as technological connection failure, and you are having an emergency, do not call me back; instead, call 9-1-1 or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-connect you via the telehealth platform on which we

agreed to conduct treatment. If I do not connect via the telehealth platform within two (2) minutes, then call me at the Family Health office phone number I provided you (937-548-9680).

Fees

The same fee rates will apply for telehealth as apply for in-person appointments. It is important that you contact your insurer to determine if there are applicable co-pays or fees which you are responsible for. Insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic therapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telehealth sessions in order to determine whether these appointments will be covered.

If there is a technological failure and we are unable to resume the connection, your provider will code to the specificity of what you were able to complete during the appointment.

Records

The telehealth sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our treatment together and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

_____ _____

Patient Signature or Patient Representative Date

_____ _____

Patient Name DOB

PATIENT RIGHTS AND RESPONSIBILITIES

Our purpose is to assist our patients in "…building healthy lives" through integrated and coordinated care. To achieve good health requires your full participation. We cannot give you "good health," but we can be a valuable partner in this effort. This partnership requires that we both respect this relationship.

You have a right to:

A response to your request for treatment, within the scope of Family Health's mission, capacity, and protocols. The individuals treating you should be identified by name and their professional status made know to you.

Receive courteous, considerate, and respectful behavior from all staff members.

Request assistance if your vision, hearing, English language skills, or other situations limit your full and informed participation in your care process.

Confidential treatment. You have the right to approve or disapprove the release of any records except when law requires release.

Information regarding your diagnosis, treatment, and prognosis so you can participate in decisions about the intensity and scope of your treatment.

Care that takes into consideration your psychological, social, and cultural values.

Accept or refuse treatment to the extent permitted by law. You also have the right to be informed of the medical consequences of refusing treatment.

Consider ethical issues that arise in your care. You have the right to have your guardian, next of kin, or legally authorized responsible person make decisions for you if you are unable to participate yourself.

Be made aware of advance directives, (Living Will, DNR orders, etc.) and to know how this organization will respond to such advance directives.

You have the responsibility to:

Be prompt for all scheduled appointments.

Cancel an appointment within 24-hours.

Follow the medical treatment plan developed between you and your physician/clinician. If you do not believe you can complete the treatment plan for any reason we ask that you make your concerns known to the clinician caring for you so that other options can be considered.

Be courteous and respectful to all staff and other patients and visitors.

Pay the required fee at time of service. If unable to do so, it is your responsibility to make other financial arrangements with our billing department.

If you feel your rights have been violated or are not pleased with your care at Family Health in any way, please ask to speak with an administrator or call us at 937-548-3806.

FAMILY Health
Building healthy lives Together

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures
Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **Family Health**. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written retraction of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to retract your authorization.

Additional Uses of Information
Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Fund-raising. Unless you request us not to, we would be able to use your name and address to support any fund-raising efforts we might undertake. If you do not want to participate in fund-raising efforts, please check off the box on the Acknowledge of Receipt form you will sign proving you received this privacy notice.

Ohio Health Information
Your doctors and healthcare providers can use the electronic network to securely provide access to your health records for a better picture of your health needs. We and other healthcare professionals may allow access to your health information through the CliniSync Health Information Exchange for treatment, payment, or other healthcare operations.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to received a printed copy of this notice

Family Health's Responsibilities
We are required by law to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by asking the receptionist or privacy officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, or if you believe your privacy rights have been violated, you can do so by sending a letter outlining your concerns to the address below or by call the administration department at 937-548-3806.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

Privacy Officer
Family Health Services of Darke County
5735 Meeker Rd.
Greenville, Oh 45331
937-548-3806

Effective Date
This notice is effective on or after April 1, 2003.
Amended: July 9, 2013, April 12, 2022
Jared Pollick, Executive Director

FAMILY Health
Building healthy lives Together

No-Show Policy

1st No-show, a card will be sent

2nd No-show, a letter will be sent informing the patient they have been converted to Stand-By-Status.

- ❖ While in Stand-By Status, when you need an appointment:
  - Call or inquire at the front office for a same day/stand-by appointment
  - You will be advised of the time frame in which an appointment **may become** available.
  - Once you are waiting in the parking lot, please notify the front office.
- ❖ **Stand-By Status** Once you complete two stand-by visits, you are reinstated to regular status. If you fall back into stand-by status, you will no longer be able to schedule appointments with Family Health in any department.

Please be responsible and notify Family Health at least 24 hours in advance if unable to keep an appointment time and arrive within a 15-minute timeframe of the start of the scheduled appointment.

PAYING FOR CARE

We pride ourselves on our unique commitment to providing healthcare for all individuals, regardless of their insurance, financial status or ability to pay, offering solutions such as sliding fees to ensure accessibility.

Insurance
Patient Navigators are available to answer questions and assist patients about insurance coverage. Please bring your insurance cards to each appointment.

Payment for services
Co-pays and deductibles not covered by insurance plans are due on the day of services.

Discounted rates
Discounted sliding fee program for qualified individuals are available.

Prescriptions
Discounted prescriptions may be available through pharmacy Patient Assistance programs for qualified individuals.

OUR BOARD

A Board of Directors, made up of health center patients, community members and area professionals governs FHS. The board oversees policy, budget, quality improvement, and decisions impacting the Health Center.

ESTABLISH YOUR PATIENT-CENTERED MEDICAL HOME WITH FAMILY HEALTH SERVICES TODAY TO BUILD HEALTHY LIVES TOGETHER.

Same day scheduling and extended hours are available. Call center staff will assist in scheduling appointments or check our online scheduling option.

Please see our website for hours and locations:

familyhealthservices.org

937-548-9680

FEDERAL TORT CLAIMS ACT
HRSA Health Center Program
FSHCAA Deemed Health Center

PATIENT-CENTERED MEDICAL HOME

Family Health Services of Darke County is an accredited Patient-Centered Medical Home (PCMH), which is a system of care in which medical professionals work together as a team to provide all of your health care needs.

It is NOT a building! It is a model of care designed to improve the coordination of your health care with an emphasis on your overall well-being. The goal of our health care team is to provide the best possible outcomes for you.

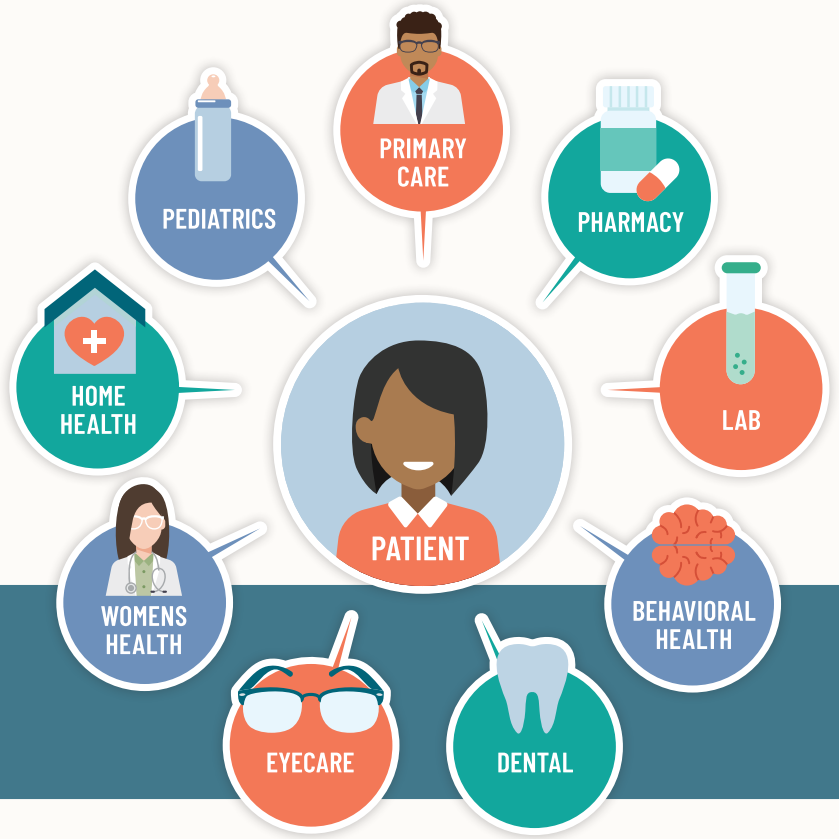
FAMILY Health

BUILDING HEALTHY LIVES TOGETHER

As our patient, YOU are the center of your care team and the most important part of the Patient-Centered Medical Home team.

When you take an active role in your health and work closely with your care team, you can be sure you are getting the care you need. Your care team involves you in decisions about your health care, which helps you to develop a stronger relationship with them.

The primary goal of the care team is to coordinate and provide the services and care that are right for you. Your care team can include your primary care provider, clinical staff, care managers, behavioral health and wellness, pharmacy, dental, lab, support staff, WIC and front desk personnel. The team also strives to offer support and services to your family as part of the PCMH team, including care coordination activities for specialists.



Core Principles of PCMH:

- Ongoing relationship with your primary care physician and the treatment team that supports your health, such as acute care providers and specialists
- Whole-person perspective and care
- Coordinated and integrated providers and systems
- Centralized quality and safety
- Enhanced access to care

What PCMH Means for You:

- Comprehensive primary care (personal and focused on quality care)
- Electronic medical records and patient portals to communicate and coordinate your care →
- Actively working to maintain your records and minimizing care gaps through personalized outreach when certain test and/or lab results are not in your chart.

Family Health provides primary care and health education for pediatrics through senior health care, behavioral health and wellness, women's health, dental, eyecare, pharmacy and home health services.

FAMILY Health

340B Helps Us Help You!

We participate in a federal government program known as the **340B drug pricing program**. This requires most drug companies to provide discounts to safety net hospitals and clinics at no cost to the taxpayer.

What this means for you:

- Helps us provide affordable medications to our patients
- Comprehensive care for more patients regardless of insurance status
- Providing access to management of chronic care diseases such as diabetes, COPD/asthma, and high blood pressure
- Provide more services such as:
  - Dental, vision, behavioral health, pharmacy and delivery
- Offset losses from providing care without compensation

Building healthy lives Together

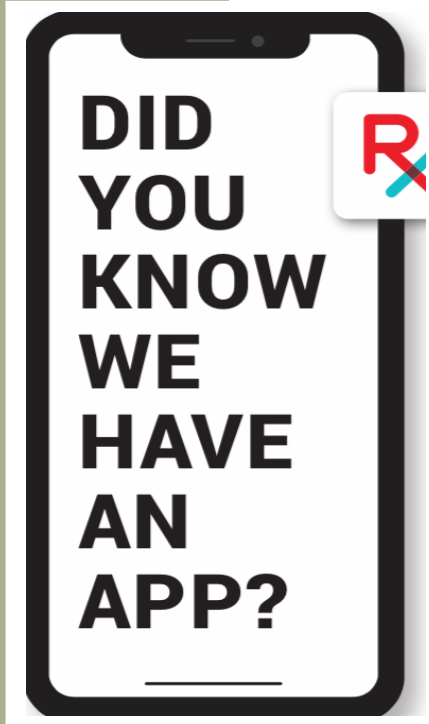
Family Health Pharmacy

Now offering:

Prescription delivery and Curb side pick-up

- **FREE** deliveries Monday through Friday
  - 1:00PM to 5:00PM
  - 1 free delivery each calendar month. Afterwards, subject to $5 delivery charge
- Must fill prescriptions at Family Health Pharmacy
- Recommended to be enrolled in the free medication synchronization (med sync) program
- Address must be in Ohio within 20 miles of the Family Health Greenville location
- No delivery on Saturdays or observed holidays
- Upon delivering, someone has to be present in order to sign for the prescription delivery

RxLocal



Mobile Refills

Order and manage medication refills using your phone.

Reminders

Set reminders to pick up or request refills.

Set reminders to take your medications.

Can Select Delivery or Pick Up

If you have any questions, please call the pharmacy at 937-548-2953.

Discount Services Offered

- Medical office visits/procedures
- After hours visits
- Nursing home visits
- Hospital visits
- Pharmacy
- Behavioral Health Counseling / Social Services
- Imaging and laboratory
- Dental services
- Eyecare services

Discounts may not apply or may vary depending on the supply, prescription and/or procedure.

Income Considerations

The sliding fee discount is based on family size and total gross income (yourself, spouse or significant other, children under 18, and parents, grandparents and adult children if applicable).

Gross income is the amount you make before deductions and taxes. This would be your adjusted gross income on your taxes, plus any non-taxed social security, child support, alimony, unemployment, and pension.

If unemployed, come in and fill out a No Proof of Income Form and explain how you are being supported.

Are you one of Ohio's thousands who do not have health insurance?

We understand that it is not always possible for patients to be covered by health insurance.

Family Health Services offers a sliding fee program to assist patients who may not qualify for public benefits and who are not able to afford the full cost of an office visit. Each family unit will be determined eligible by comparing their household family size and income to the Federal Poverty Guidelines, which are updated every year.

We also offer a prompt pay discount for those who do not qualify for the sliding fee or who's insurance does not cover the cost of office visits.

This brochure is meant to help you understand our sliding fee program. We are here to help you and your family build a healthy life!

If you would like Marketplace insurance or Medicaid counseling and application assistance, this free service is available. Call the Certified Application Counselor for more information. 937-547-2330

www.familyhealthservices.org

FAMILY Health

Building healthy lives together.

Sliding Fee Program

COMMUNITY HEALTH CENTER FQHC QUALITY

Accredited by Accreditation Association for Ambulatory Health Care, Inc.

HRSA FTCA Deemed

Family Health Services of Darke County, Inc.

Sliding Fee Discount Schedule 2024-2025

Effective Dates: February 1, 2024 - March 31, 2025

	Slide A	Slide B	Slide C	Slide D	Slide E	Slide F
% Federal Poverty Guidelines	0% - 100%	101 - 125%	126 - 150%	151 - 175%	176 - 200%	Above 200%
Medical, Behavioral Health, and Vision	$25 nominal charge	$35	$55	$65	$85	full fee
Adherence Packaging Visits	$5 nominal charge	$6	$7	$8	$9	full fee
Pharmacy Brand ($5 Minimum)	75% until $25 nominal charge	70% until $30 maximum	65% until $35 maximum	60% until $40 maximum	55% until $45 maximum	full fee
Pharmacy Generic ($5 Minimum)	95% until $15 nominal charge	90% until $20 maximum	85% until $25 maximum	80% until $30 maximum	75% until $35 maximum	full fee
OB Visits with Delivery	$1,800 nominal charge	$1,900	$2,000	$2,100	$2,200	full fee
OB Delivery Only	$900 nominal charge	$1,000	$1,100	$1,200	$1,300	full fee
Family Size	**Annual Income**					
1	$0 - $ 15,060	$15,061 - $ 18,825	$18,826 - $ 22,590	$22,591 - $ 26,355	$26,356 - $ 30,120	$ 30,121 +
2	$0 - $ 20,440	$20,441 - $ 25,550	$25,551 - $ 30,660	$30,661 - $ 35,770	$35,771 - $ 40,880	$ 40,881 +
3	$0 - $ 25,820	$25,821 - $ 32,275	$32,276 - $ 38,730	$38,731 - $ 45,185	$45,186 - $ 51,640	$ 51,641 +
4	$0 - $ 31,200	$31,201 - $ 39,000	$39,001 - $ 46,800	$46,801 - $ 54,600	$54,601 - $ 62,400	$ 62,401 +
5	$0 - $ 36,580	$36,581 - $ 45,725	$45,726 - $ 54,870	$54,871 - $ 64,015	$64,016 - $ 73,160	$ 73,161 +
6	$0 - $ 41,960	$41,961 - $ 52,450	$52,451 - $ 62,940	$62,941 - $ 73,430	$73,431 - $ 83,920	$ 83,921 +
7	$0 - $ 47,340	$47,341 - $ 59,175	$59,176 - $ 71,010	$71,011 - $ 82,845	$82,846 - $ 94,680	$ 94,681 +
8	$0 - $ 52,720	$52,721 - $ 65,900	$65,901 - $ 79,080	$79,081 - $ 92,260	$92,261 - $ 105,440	$ 105,441 +

For Families/households with more than 8 persons, add $5,380 for each additional person.

Renewing Your Sliding Fee

It is important to keep your sliding fee information current. Please be sure to:

- Notify us promptly of income changes or family size
- Renew your sliding fee every 12 months

Note: If your sliding fee expires you will be responsible for the full cost of your visits. Once your paperwork is current, your sliding fee will be re-instated.

Important Information

Family Health Services has a limited amount of funds for this program. We want to assure that the discounts are available to the patients who need them most. Therefore, we request that you:

- Provide ALL of the required information
- Pay your full fee at the time of your doctor visit

We also offer a prompt-pay discount. If payment is made in full at the time of service a 20% discount can be made for Dental and Eyecare office visits or 30% discount for Medical and Behavioral Health office visits. You may choose this option if you do not qualify for the sliding fee discount or if your insurance does not cover the office visit.

Call any front office receptionist for more information on the sliding fee discount.

- Greenville: 937-548-9680
- Behavioral Health: 937-547-2319
- Dental: 937-547-2326
- Arcanum: 937-692-6601
- Versailles: 937-526-3016
- New Madison: 937-996-0023
- Vision: 937-548-6111

Print Date: 02/05/2024

Building Healthy Lives Together

Dental Sliding Fee Discount Schedule 2024-2025

Effective Dates: February 1, 2024 - March 31, 2025

	Slide A	Slide B	Slide C	Slide D	Slide E	Slide F
% Federal Poverty Guidelines	0% - 100%	101 - 125%	126 - 150%	151 - 175%	176 - 200%	Above 200%
Per Visit: Regular Visits, Sealants, Some Minor Surgeries and Procedures, Space Maintainers	$35 nominal charge	$45	$55	$65	$85	full fee
Per Tooth: Extractions, Stainless Steel Crowns , 1-3 Surface Fillings						
Per Quadrant: Advanced Cleanings						
Per Arch: In-Office Relines	$80 nominal charge	$90	$100	$110	$120	full fee
Per Visit: Other Surgeries and Procedures						
Per Tooth: 4 or more Surface Fillings and Core Build Ups						
Per Tooth: Root Canals and Cerec Crowns	$110 nominal charge	$120	$130	$140	$150	full fee
Brux Appliances and 3D Pano						
Per Visit: Other Surgeries and Procedures						
Dentures, Paritals, Major Surgeries and Procedures, Other	45% up to $485 nominal charge	40% up to $500 nominal charge	35% up to $520 nominal charge	30% up to $540 nominal charge	25% up to $570 nominal charge	full fee
Per Arch: Lab Relines						
Per Tooth: Custom Crowns						
Interceptive and Limited Ortho Treatment	$600 nominal charge	$700	$800	$900	$1,100	full fee
Family Size	**Annual Income**					
1	$0 - $ 15,060	$15,061 - $ 18,825	$18,826 - $ 22,590	$22,591 - $ 26,355	$26,356 - $ 30,120	$ 30,121 +
2	$0 - $ 20,440	$20,441 - $ 25,550	$25,551 - $ 30,660	$30,661 - $ 35,770	$35,771 - $ 40,880	$ 40,881 +
3	$0 - $ 25,820	$25,821 - $ 32,275	$32,276 - $ 38,730	$38,731 - $ 45,185	$45,186 - $ 51,640	$ 51,641 +
4	$0 - $ 31,200	$31,201 - $ 39,000	$39,001 - $ 46,800	$46,801 - $ 54,600	$54,601 - $ 62,400	$ 62,401 +
5	$0 - $ 36,580	$36,581 - $ 45,725	$45,726 - $ 54,870	$54,871 - $ 64,015	$64,016 - $ 73,160	$ 73,161 +
6	$0 - $ 41,960	$41,961 - $ 52,450	$52,451 - $ 62,940	$62,941 - $ 73,430	$73,431 - $ 83,920	$ 83,921 +
7	$0 - $ 47,340	$47,341 - $ 59,175	$59,176 - $ 71,010	$71,011 - $ 82,845	$82,846 - $ 94,680	$ 94,681 +
8	$0 - $ 52,720	$52,721 - $ 65,900	$65,901 - $ 79,080	$79,081 - $ 92,260	$92,261 - $ 105,440	$ 105,441 +

For Families/households with more than 8 persons, add $5,380 for each additional person.