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)
- **Your current medications in original bottles.**

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**

FAMILY Health
BUILDING HEALTHY LIVES TOGETHER

## PATIENT INFORMATION:

| Last Name | First Name | MI | Preferred Name | 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 ☐e-Message

**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

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

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

**Ethnicity:**
☐ Non-Hispanic or Latino/Or Spanish Origin
☐ Hispanic or Latino/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:**
$_____

☐ **Refuse to report**

**Preferred Pharmacy:**
_____

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

☐ Kiosk Check-In

**FAMILY HEALTH SERVICES**
**PATIENT REGISTRATION FORM**

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| **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.

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# Consent to Treat Minor Patient

**Minor Patient's Name: _____ Date of Birth: _____**

**What Ohio Law Says About Minor Consent:**

***Situations When a Minor Can Consent***

Ohio law generally requires the consent of a minor patient's parent or guardian before the minor is treated for most health care services. However, Ohio law permits minor patients to consent to receiving some health care services without also needing parental consent. Those services include:

a. Physical examination by a physician, a physician assistant, a clinical nurse specialist, a certified nurse practitioner, or a certified nurse-midwife of a minor who is a victim of a sexual offense at a hospital with organized emergency services, with written notification to the parent or guardian that such examination has taken place;

b. Diagnosis and treatment of a venereal disease by a licensed physician;

c. Outpatient mental health services (excluding the use of medication) at the request of a minor fourteen (14) years of age or older. However, if (1) the treatment spans more than thirty (30) days or six visits, whichever occurs sooner, or (2) the mental health professional treating the minor determines that there is a compelling need for disclosure based on a substantial probability of harm to the minor or to other person, and the minor is notified of the disclosure, then parental notification is required;

d. Diagnosis or treatment by a licensed physician for substance abuse of any condition which is reasonable to believe is caused by a drug of abuse, beer, or intoxicating liquor; and

e. Emergency medical treatment to preserve life and prevent serious impairment.

**General Consent to Treat a Minor Patient:**

I, _____, the minor patient or the parent/legal guardian of the minor patient, request and authorize Family Health Services of Darke County, Inc. (Family Health Services) and its personnel to deliver routine medical, dental, vision, speech therapy, and behavioral health care that may be deemed necessary or advisable in the diagnosis and treatment of the minor patient. Care may include, but is not limited to, medical evaluation, physical examination, dental cleanings, diagnoses, review of history including sexual/mental/emotional traumas, immunizations, therapeutic injections, dental x-rays, lab work (including, but not limited to throat or nasal swabs and blood draws), wart treatment with liquid nitrogen, minor burns, and minor suturing of lacerations. I understand that a Family Health Services provider will review the minor patient's history before making any new diagnoses. I give consent for the Family Health Services provider to diagnose or treat the minor patient as deemed appropriate.

I understand that I am financially responsible for the costs of services that are not billed to third-party payors. I understand that payment is expected at the time of treatment. I understand that my income will be used to determine my eligibility for a financial need discount and my financial responsibility for services to which I consent.

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# Consent to Treat Minor Patient

**Limitations:**

Identify any specific limitations on the kinds of services for which this authorization is given. (If none, state "none").

_____

_____

If the minor patient arrives with someone other than their parent or legal guardian, or arrives unaccompanied, then the parent or legal guardian must authorize the adult accompanying the minor to act on the parent or guardian's behalf. If the minor patient can consent to their own health care services, then they may receive such services, even if they are unaccompanied.

**Please list the adults that may consent to the minor patient's care:**

Name: _____Phone: _____ Relation to Patient: _____

Name: _____Phone: _____ Relation to Patient: _____

Name: _____Phone: _____ Relation to Patient: _____

I voluntarily give my consent as stipulated above. My signature means that I have read this consent form and/or have had it read to me and explained in a language that I can understand. This consent form shall be in effect until revoked by written notice.

_____

Parent or Legal Guardian  Phone Number  Relationship to Minor Patient

_____

Parent/Guardian Signature  Date

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Dear Parent/Guardian,

Family Health Services of Darke County is dedicated to providing the best quality of care to our patients. Our providers have come together to recognize that this includes educating and protecting children and their families against certain diseases and the vaccines that prevent them. Please ensure that you read this document in its entirety. You will be asked to sign a copy of this letter to show that you have read and understand the requirements associated with the minor in your care receiving services with our facility.

To increase awareness about vaccine preventable diseases, various members of our team have worked together to research these diseases and then created/recorded videos to provide education to all parents/guardians. The team has also researched and compiled other additional educational materials that may be used to assist in the education process.

All parents/guardians of minors ages 0-18 who have chosen to fully vaccinate or partially vaccinate the minor in their care will only be required to review age-appropriate vaccine education materials for any/all missed, declined, or due vaccinations.

All parents/guardians of minors ages 0-18 who choose not to vaccinate the minor will be required to participate in the educational process set by Family Health. They will also be required to sign the vaccine refusal form for required vaccines set in place by the Centers for Disease Control and Prevention (CDC) guidelines.

Family Health will not require you to vaccinate your children. However, we will be providing educational materials to you to assist with the recognition of the disease process to aid in early identification for the minor in your care. This will also help protect the clinic and the community. Those who choose not to vaccinate their children will still need to follow the refusal to vaccinate policies and procedures of Family Health.

If you, as the parent/guardian, refuse to participate in the educational process, you will be provided with one additional opportunity to participate in the program. This additional opportunity will be presented at the minors' next routine or wellness visit with their primary care provider. If you continue to refuse to participate in the program, the minor will be dismissed from the practice and will need to find a new medical provider outside of Family Health Services. The process for dismissal will follow the Family Health Patient Dismissal Policy.

If you have any questions about the information above, please feel free to contact your primary care provider. Thank you for the role you and your family play in helping us Build Healthy Lives Together.

Child's Name: _____ DOB: _____

Attestation:

I hereby attest that I have read the above information in its entirety, and I understand what is required of me.

_____ _____

Parent/Guardian Signature Date

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# Pediatric Comprehensive Patient History

☐ New Patient ☐ Established Patient Today's Date: _____

**Parent(s) Name:** _____

**Child's Full Name:** _____ Date of birth: _____ Sex ☐ M ☐ F

**Child's Doctor:** _____ Referred by: _____

**Child's Medical History** ☐ Unknown ☐ No Significant Medical History

## Complete below section if child is less than 5 years old or if there was a significant/complicated pregnancy history

**Pregnancy/Birth History:** *Check all that apply*
☐ Mother's age at delivery _____
Month prenatal care began _____
Weeks of pregnancy _____
Birth Weight _____ ☐ C-Section ☐ Vaginal

**Pregnancy Complications:**
☐ Infections ☐ Diabetes ☐ Pre-eclampsia
☐ Multiple Gestations _____
☐ Other _____

**Birth/Newborn Complications:**
☐ Other _____
_____
☐ Premature? – How early? _____
☐ NICU stay? – How long? _____

**Medications:** _____
_____
☐ Infections _____
_____

**During pregnancy, the child's mother:**
☐ Smoked - How much? _____
☐ Drank alcohol - How much? _____

**Current Medications:**
_____
_____
_____

**Allergies to Medicines:**
_____
_____
_____

**Reaction:**
_____
_____
_____

**This Child has been DIAGNOSED with:**

| | | |
|---|---|---|
| ☐ ADD/ADHD | Age:_____ | |
| ☐ Allergies/Hay fever | Age:_____ | |
| ☐ Anemia | Age:_____ | |
| ☐ Asthma | Age:_____ | |
| ☐ Autism | Age:_____ | |
| ☐ Bipolar Disorder | Age:_____ | |
| ☐ Blood Disorder/Sickle Cell | Age:_____ | |
| ☐ Broken Bones - Detail below | | |
| _____ | Age:_____ | |
| _____ | Age:_____ | |
| ☐ Cancer - Type: _____ | | |
| | Age:_____ | |
| ☐ Celiac Disease | Age:_____ | |
| ☐ Chicken Pox | Age:_____ | |
| ☐ Constipation | Age:_____ | |
| ☐ Depression | Age:_____ | |
| ☐ Developmental Delay | Age:_____ | |
| ☐ Diabetes | Age:_____ | |
| ☐ Frequent Ear Infections | Age:_____ | |
| ☐ Gastrointestinal disorder | Age:_____ | |
| ☐ Headaches/migraines | Age:_____ | |
| ☐ Learning Disability | Age:_____ | |
| ☐ Pneumonia | Age:_____ | |
| ☐ Scoliosis (curved spine) | Age:_____ | |
| ☐ Seizures/epilepsy | Age:_____ | |
| ☐ Skin Issues | Age:_____ | |
| ☐ Stomach Problems | Age:_____ | |
| ☐ UTI/Bladder Infections | Age:_____ | |
| ☐ Other _____ | | |

**Child's SURGERIES** ☐ None

| | | | |
|---|---|---|---|
| ☐ Appendectomy | Age:_____ | ☐ Eye Surgery | Age:_____ |
| ☐ Adenoidectomy | Age:_____ | ☐ Hernia repair | Age:_____ |
| ☐ Ear Tubes | Age:_____ | ☐ Tonsillectomy | Age:_____ |
| ☐ Other _____ | Age:_____ | | |
| ☐ Other _____ | Age:_____ | | |

**Child's Hospitalizations:**
Hospitalization: _____ Age: _____
Hospitalization: _____ Age: _____
Hospitalization: _____ Age: _____
Hospitalization: _____ Age: _____

**Child's Family History:** Check the diagnoses given to the child's relatives. ☐ **Unknown**

**Please circle relationship M=Mother, F=Father, S=Sibling(s), GM = Grandmother, GF=Grandfather, O=Other Relative(s)**

| Diagnosis of relative: | Relationship to child | Diagnosis of relative: | Relationship to child |
|---|---|---|---|
| ☐ ADD | M F S GM GF O | ☐ High Blood Pressure | M F S GM GF O |
| ☐ Allergies | M F S GM GF O | ☐ High Cholesterol | M F S GM GF O |
| ☐ Anemia | M F S GM GF O | ☐ Learning Disability | M F S GM GF O |
| ☐ Asthma | M F S GM GF O | ☐ Psychiatric Illness (Depression, addiction, etc) | M F S GM GF O |
| ☐ Autism | M F S GM GF O | ☐ Seizures/epilepsy | M F S GM GF O |
| ☐ Blood Disorder/ Sickle Cell | M F S GM GF O | ☐ SIDS (crib death) | M F S GM GF O |
| ☐ Cancer | M F S GM GF O | ☐ Stroke before age 55 | M F S GM GF O |
| ☐ Celiac Disease | M F S GM GF O | ☐ Sudden Death before age 50 | M F S GM GF O |
| ☐ Diabetes | M F S GM GF O | ☐ Other _____ | M F S GM GF O |
| ☐ Gastrointestinal disorder | M F S GM GF O | | |
| ☐ Heart disease before age 55 | M F S GM GF O | | |

**Social/Environmental**
Child lives w/:
☐ Parent(s): ☐ Together ☐ Apart/Shared
☐ Mother
☐ Father
☐ Relative _____
☐ Other _____

Adopted ☐
Smokers live in home with child? ☐ Yes ☐ No
Child attends day care? ☐ Yes ☐ No
Pets in the home? ☐ Yes ☐ No
Well water? ☐ Yes ☐ No
Home built before 1960? ☐ Yes ☐ No

Other _____
_____
_____
_____
_____

**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

# 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 10-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.

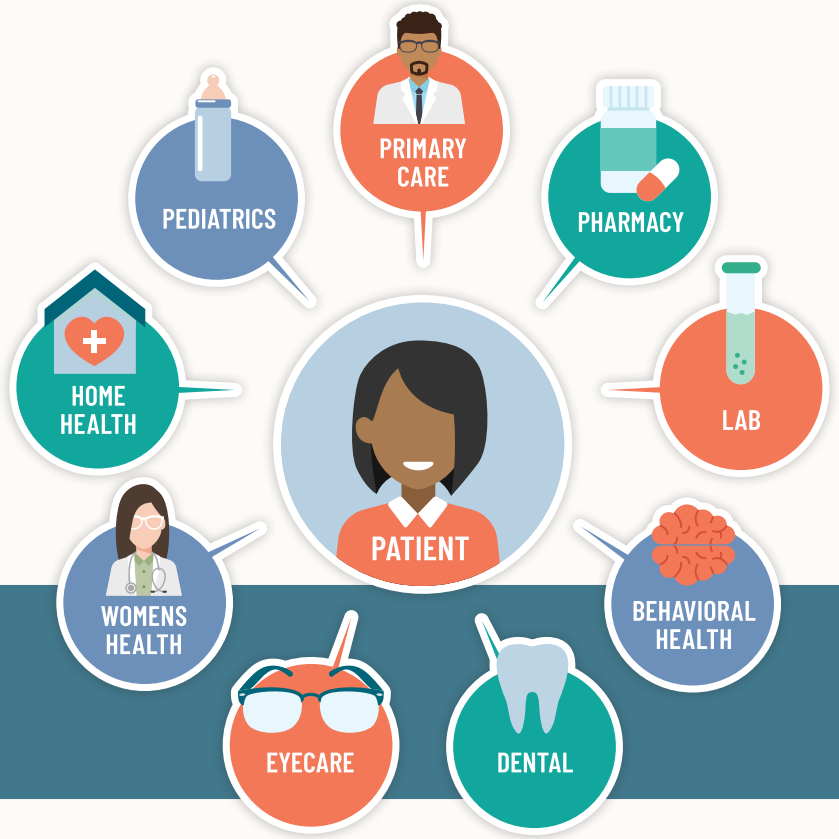
FAMILY Health

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

BUILDING HEALTHY LIVES TOGETHER

# 340B Helps Us Help You!

Family Health participates in a federal government program known as the **340B drug pricing program,** which allows us to:

- Offer more affordable medications
- Care for more patients, regardless of insurance
- Treat chronic diseases like diabetes, asthma & more
- Expand services like dental, vision, and pharmacy and delivery
- Offset losses from care we provide at low/no cost

**This means better care, at better value – for you!**

# FAMILY Health PHARMACY

## HOW TO USE OUR PHARMACY SERVICES

# Drive-Thru and Delivery Available!

**We Make It Easy for You to Get Your Medications!**

- Convenient drive-thru service
- Free home delivery available Monday through Friday 1:00 PM - 5:00 PM
- Manage it all with our free RxLocal app

**A few things to know:**

- Must use Family Health Pharmacy
- Deliveries within 20 miles of our Greenville location
- Enroll in Med Sync for easy scheduling
- Signature required on delivery
- No weekend or holiday deliveries


RxLocal

Sign up here today!

### MOBILE REFILLS

Order and manage medication refills using your phone.

### 2-WAY MESSAGING

Send messages directly to your pharmacist in-app 24/7

### REMINDERS

Set reminders to pick up and request refills, or to take your medications.

### SELECT DELIVERY OR PICKUP

5735 Meeker Rd., Greenville, OH 45331 | 937-548-2953 | familyhealthservices.org

## 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 (including 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.

COMMUNITY HEALTH CENTER FQHC QUALITY

Accredited by Accreditation Association for Ambulatory Health Care, Inc.

HRSA FTCA Deemed

## 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 whose 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**.

# SLIDING FEE PROGRAM

FAMILY Health

5735 Meeker Road Greenville, OH 45331
Tel: 937-548-9680 • Fax: 937-548-2087

# Sliding Fee Discount Schedule 2026-2027

Effective Dates: February 3, 2026 to March 31, 2027

| | 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 - $ 15,960 | $15,961 - $ 19,950 | $19,951 - $ 23,940 | $23,941 - $ 27,930 | $27,931 - $ 31,920 | $ 31,921 + |
| 2 | $0 - $ 21,640 | $21,641 - $ 27,050 | $27,051 - $ 32,460 | $32,461 - $ 37,870 | $37,871 - $ 43,280 | $ 43,281 + |
| 3 | $0 - $ 27,320 | $27,321 - $ 34,150 | $34,151 - $ 40,980 | $40,981 - $ 47,810 | $47,811 - $ 54,640 | $ 54,641 + |
| 4 | $0 - $ 33,000 | $33,001 - $ 41,250 | $41,251 - $ 49,500 | $49,501 - $ 57,750 | $57,751 - $ 66,000 | $ 66,001 + |
| 5 | $0 - $ 38,680 | $38,681 - $ 48,350 | $48,351 - $ 58,020 | $58,021 - $ 67,690 | $67,691 - $ 77,360 | $ 77,361 + |
| 6 | $0 - $ 44,360 | $44,361 - $ 55,450 | $55,451 - $ 66,540 | $66,541 - $ 77,630 | $77,631 - $ 88,720 | $ 88,721 + |
| 7 | $0 - $ 50,040 | $50,041 - $ 62,550 | $62,551 - $ 75,060 | $75,061 - $ 87,570 | $87,571 - $ 100,080 | $ 100,081 + |
| 8 | $0 - $ 55,720 | $55,721 - $ 69,650 | $69,651 - $ 83,580 | $83,581 - $ 97,510 | $97,511 - $ 111,440 | $ 111,441 + |

For Families/households with more than 8 persons, add $5,680 for each additional person.

5680

Guidelines: 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). It may not be applicable for certain supplies and goods.

If your FAMILY INCOME falls within the above guidelines, you may qualify for our sliding-fee discount program. Please ask the receptionist for more information.

## 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 reinstated.

## 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. There are a few exceptions. 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

**BUILDING HEALTHY LIVES TOGETHER**

# Dental Sliding Fee Discount Schedule 2026-2027

Effective Dates: February 3, 2026 to March 31, 2027

| | 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<br>Per Tooth: Extractions, Stainless Steel Crowns , 1-3 Surface Fillings<br>Per Quadrant: Advanced Cleanings | $35 nominal charge | $45 | $55 | $65 | $85 | full fee |
| Per Arch: In-Office Relines<br>Per Visit: Other Surgeries and Procedures<br>Per Tooth: 4 or more Surface Fillings | $80 nominal charge | $90 | $100 | $110 | $120 | full fee |
| Per Tooth: NonMolar Root Canals and In-House Cerec Crowns<br>Brux Appliances and 3D Pano<br>Per Arch: Lab Relines<br>Per Visit: Other Surgeries and Procedures | $110 nominal charge | $120 | $130 | $140 | $150 | full fee |
| Per Tooth: Molar Root Canals | $240 nominal charge | $260 | $280 | $300 | $320 | full fee |
| Dentures, Partials, Major Surgeries and Procedures, Other<br>Per Tooth: Lab Custom Crowns | 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 |
| **Family Size** | **Annual Income** | | | | | |
| 1 | $0 - $ 15,960 | $15,961 - $ 19,950 | $19,951 - $ 23,940 | $23,941 - $ 27,930 | $27,931 - $ 31,920 | $ 31,921 + |
| 2 | $0 - $ 21,640 | $21,641 - $ 27,050 | $27,051 - $ 32,460 | $32,461 - $ 37,870 | $37,871 - $ 43,280 | $ 43,281 + |
| 3 | $0 - $ 27,320 | $27,321 - $ 34,150 | $34,151 - $ 40,980 | $40,981 - $ 47,810 | $47,811 - $ 54,640 | $ 54,641 + |
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| 5 | $0 - $ 38,680 | $38,681 - $ 48,350 | $48,351 - $ 58,020 | $58,021 - $ 67,690 | $67,691 - $ 77,360 | $ 77,361 + |
| 6 | $0 - $ 44,360 | $44,361 - $ 55,450 | $55,451 - $ 66,540 | $66,541 - $ 77,630 | $77,631 - $ 88,720 | $ 88,721 + |
| 7 | $0 - $ 50,040 | $50,041 - $ 62,550 | $62,551 - $ 75,060 | $75,061 - $ 87,570 | $87,571 - $ 100,080 | $ 100,081 + |
| 8 | $0 - $ 55,720 | $55,721 - $ 69,650 | $69,651 - $ 83,580 | $83,581 - $ 97,510 | $97,511 - $ 111,440 | $ 111,441 + |

For Families/households with more than 8 persons, add $5,680 for each additional person.

5680

Guidelines: 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). It may not be applicable for certain supplies and goods.

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