Family Health Care of Northwest Ohio
1191 Westwood Drive Van Wert, OH 45891
Phone: 419-238-6747
Fax: 419-238-3721

Notice of Privacy Practices

FOR YOUR PROTECTION

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.

YOUR RECORDS ARE PRIVATE

We understand that information we collect about you is personal. Keeping these records private is one of our most important responsibilities. Family Health Care of Northwest Ohio, Inc. (FHC) follows the HIPAA regulations which require many safeguards to protect your privacy. For this notice, we will use the term "records" to mean the paper or electronic records we maintain about you.

Your records may be used and disclosed by the employees at FHC who serve you, as well as persons or agencies who work for us and sign strict confidentiality contracts.

WHO SEES AND SHARES MY RECORDS?

In general, we may use and disclose your information for treatment, payment and healthcare operations. Specific examples include:

- Providing treatment for your physical and/or emotional illness, including ordering lab tests, making referrals to other healthcare providers, and consulting with other medical providers you have seen,
- To secure payment, for example, a billing clerk will electronically transmit billing information to your insurance company or 3rd party payer
- Certain business associates, who are under contract to maintain confidentiality, may see your information. For example, if you accidently overpay, and we send a refund check, our accountant may see this refund check.
- For other operations to operate and manage FHC: these include improving quality of care, training staff, managing costs, and conducting other business duties. For example, a quality assurance reviewer may audit your records to determine whether appropriate services were provided,
- To remind you of an appointment for services,
- To raise funds for FHC. You have the right to opt out of receiving these communications.

COULD MY RECORDS BE RELEASED WITHOUT MY PERMISSION?

There are limited situations when we are permitted or required to disclose your records, or parts of them, without your signed permission. These situations include:

- Reports to public health authorities to prevent or control disease or other public health activities,
- To protect victims of abuse, neglect, or domestic violence,
- For oversight including investigations, audits, accreditation and inspections, such as are conducted by the State Department of Health, or State Pharmacy Board, and federal agencies,
- When a court order, subpoena or other legal process compels us to release information,
- Reports to law enforcement agencies when reporting suspected crimes, when responding to an emergency, or in other situations when we are legally required to cooperate,
- In connection with an emergency, or to reduce or prevent serious threat to yourself and/or public health and safety,
- to coroners, medical examiners and funeral directors,
- to victims of alleged violence or sex offenses,
- For workers' compensation programs,
- For specialized government functions including national security, protecting the president, operating government benefit programs, and caring for prisoners,
- In connection with "whistleblowing" by an employee of FHC.

All other uses not described above require that we obtain your signed permission as described below.

WHAT IF MY RECORDS NEED TO GO SOMEWHERE ELSE

For any purpose not described above, we will release your information only with your explicit written authorization. Federal law requires that we notify you that all healthcare providers must obtain your explicit permission to release your information for any of the following:

1. For marketing purposes,

2. To sell information about you.

Please note that it is not and has never been this organization's policy to sell information about you or to use your information for marketing.

Your written permission, called an "authorization," tells us what, where, why and to whom the information must be sent. Your signed authorization is valid until the date you specify. You can revoke this authorization at any time by letting us know in writing.

WHAT ARE MY RIGHTS REGARDING PRIVACY, ACCESS TO MY RECORDS, AND THE ACCURACY OF MY RECORDS?

You have legal rights concerning your privacy, access to your records, and the accuracy of your records:

1. If you request, we will show you your records, or give you a copy.
2. If you think some of the information is wrong, you may ask that it be changed, or that new information be added.
3. If you request, we will mail all communications to a confidential address.
4. If you request, we will provide a list of any places where your records have been sent.
5. You may request that we make additional limits on how we use or disclose your information. We must honor requests to not bill a 3rd party payer if you pay the invoice in full. For other requests, we will consider but are not obliged to honor these requests.
6. You may receive a paper copy of this notice.

To exercise any of these rights, mail to:

HIPAA Privacy Officer

Family Health Care of Northwest Ohio, Inc.

1191 Westwood Drive

Van Wert, Ohio 45891

OUR DUTIES

We are required by law to abide by the terms of this notice. In the event of a breach, that is, an unintended release of your information contrary to these practices, we will notify you via first class mail. From time to time we may make changes to our policies, and if and when we do, your records will be protected by our new, changed policies. Our current notice will always be available on our website.

QUESTIONS OR COMPLAINTS?

If you have any questions about this notice, or you think that we have not protected your records and you wish to complain about any privacy or records access matter, please contact:

Attn: HIPAA Privacy Officer

Family Health Care of Northwest Ohio, Inc.

1191 Westwood Drive

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We will never retaliate against you for filing a complaint. Further, if you are not satisfied with the results, you may also complain to the federal government:

Secretary of Health and Human Services

200 Independence Avenue, SW

Washington, D.C. 20201

www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

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CONSENT TO USE & DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

Patient
Name_____DOB_____SS#_____

Permission to Use & Disclose Your Health Information. By signing this consent, you authorize us to use and/or disclose your health information for treatment, payment or health care operations. You have the right not to sign this consent. However, if you refuse to sign this consent, we have the right to refuse to treat you.

Right to Review Notice of Privacy Practices. You have the right to review a copy of our Notice of Privacy Practices before signing this consent or after any revisions. Our Notice of Privacy Practices details how we may use and disclose your health information. We may amend the notice from time to time.

Right to Request Restrictions on Use/Disclosure. You have the right to request, in writing, that we restrict how we use and/or disclose your protected health information for the purpose of providing treatment, obtaining payment for our services, and/or conducting health care operations. Please note that we are not required to agree to any restriction you may request. If, however, we decide to agree to a restriction you have requested, we must restrict our use and/or disclosure of your health information in the manner described in your request.

Right to Revoke Consent. You have the right to revoke this consent at any time, in writing. Note that your revocation of this consent will not be effective for disclosures we have already made in reliance on your prior consent. We also have the right to refuse to provide further treatment if you revoke this consent.

Right to Receive a Copy of This Consent Form. You have a right to receive a copy of this consent form after you sign it.

Effective Period. This consent is effective until you revoke it, in writing.

I have read and understand this consent and hereby authorize **Family Health Care** to use and/or disclose my health information for treatment, payment, or health care operations.

Patient's
Signature/Representative_____Date_____

Printed Name of Patient's
Representative_____Relationship_____

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Please complete the back side of this form

Effective 3/29/2007
Revised 05/01/19

Consent for Information / Treatment

Adult Patients (18 and over)

I, the undersigned patient, do hereby voluntarily consent to be given treatment by an appropriately qualified employee(s) of Family Health Care of Northwest Ohio, as is necessary in their judgment. I am aware that the practice of healthcare is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination at Family Health Care of Northwest Ohio. I understand that I may be tested and/or screened for diabetes, high cholesterol, depression, alcohol misuse or other key markers that suggest the presence of a treatable condition. I consent to have pictures (examples include injuries, wounds, cuts, bruises, etc.) taken only if it is necessary as part of my care and treatment. These pictures will remain as part of my health record. Authorization is hereby granted to receive treatment for physical and/or emotional illness as part of medical, dental, clinical pharmacy, behavioral health and/or substance misuse visits.

I authorize Family Health Care Medical, Clinical Pharmacy, Behavioral Health & Dental Staff to give information concerning my health care (personal health information, appointment times, test results, etc.) **to the following people**:

Name(s)_____Relationship to Patient_____

Name(s)_____Relationship to Patient_____

Name(s)_____Relationship to Patient_____

If no one should receive information about your health care, please write "NONE".

Patient Signature_____Date_____

Name & Relationship to Patient (if signed by patient representative)_____

Only person(s) listed on this form will be able to receive information from Family Health Care staff about you. There will be no exceptions.

Minor Patients (Children 0-17 years)

Mother_____Father_____
(or legal guardians)

Due to HIPAA regulations, we are not permitted to give out medication information (personal health information, appointment times, test results, etc.) about your child to anyone except his or her **parents or legal guardians.** If someone other than a parent or legal guardian should have authorization to access this information, please indicate who on the lines below: (Grandparents, aunt/uncle, baby sitter, etc). Please also indicate who may give consent for MEDICAL, CLINICAL PHARMACY, BEHAVIORAL HEALTH AND DENTAL treatment (including tests, immunizations, etc.).

Name(s)_____Relationship to Patient_____

- ☐ Consent for information
- ☐ Consent for authorization of medical/behavioral health/dental treatment

Name(s)_____Relationship to Patient_____

- ☐ Consent for information
- ☐ Consent for authorization of medical/behavioral health/dental treatment

Parent/ Legal guardian's Signature_____Date_____

Printed Name _____Relationship_____

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Patient Name:_____ DOB_____

Your insurance carrier will only pay for services that they determine to be "reasonable and necessary." If your insurance carrier determines that a particular service, although it would otherwise be covered, as "not reasonable and necessary" under their standards your insurance carrier will deny payment of the service. In case your insurance carrier may deny payment, by signing below you agree to be personally and fully responsible for payment of those services. These services may include but are not limited to: Dental Procedures, Preventative Wellness Examination, Behavioral Health Visits, Clinical Pharmacy Visits, Pelvic, Breast, Pap Smear, Fecal-Occult Screenings, Prostate Exam.

Patient Signature_____Date_____

FAMILY HEALTH CARE DOES NOT PROVIDE PRE-NATAL SERVICES
FAMILY HEALTH CARE DOES NOT ACCEPT WORKERS COMPENSATION CASES

Family Health Care Board of Directors has adopted a "0 Tolerance Policy" regarding rude and/or abusive language/behavior towards any member of our staff. Failure to follow this policy could result in discharge.

"NO SHOW" POLICY

If you are unable to make your appointment, please call and cancel/reschedule no later than ***two hours*** prior to your scheduled appointment. Typically, Family Health Care has a waiting list of patients who are requesting an appointment. If you are unable to keep your appointment and you don't call to cancel in advance, we are unable to schedule another patient in your time slot.

If you do not call to cancel and you miss your appointment (if you are more than 10 minutes late, this is also considered a missed appointment), the following action will be taken:

If you miss an appointment, a letter will be mailed to you explaining the "No Show" policy. After missing three (3) appointments, you will be discharged from Family Health Care. If you wish to be readmitted after discharge, you may schedule a no show consult with the Director or Office Manager and your readmission will be considered.

I have read and agree to the above "0 Tolerance Policy" and "No Show" policy.

Name_____Date_____

Effective 3/29/2007
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PATIENT'S RIGHTS

- Patients have the right to quality services, appropriate to their health care needs, which are delivered in a timely manner.
- Patients have the right to appropriate Medically Necessary medical, dental, clinical pharmacy and behavioral health care.
- Patients have the right to reasonable access to medical, dental, clinical pharmacy and behavioral health care.
- Patients have the right to confidentiality in regard to medical and social history, individual medical records and medical information.
- Patients have the right to be treated with dignity, respect, and consideration.
- Patients have the right to be informed about personal health as it concerns medical conditions, diagnostic tests, and treatment plans.
- Patients have the right to change providers.
- Patients have the right to a second opinion.
- Patients have the right to involvement in decision-making concerning treatment.
- Patients have the right to auditory and visual privacy during a visit.
- Patients have the right to approve or refuse the release of information except when the release is required by law.
- Patients have the right to refuse treatment or therapy. Such person will be made aware of the consequences of their decision and it will be documented in the medical records.
- Patients have the right to create Advance Directives that let providers and others know the person's wishes concerning medical treatment.
- Patients have the right to assert complaints and grievances about the providers and the health care provided.
- Patients have the right to be informed about the role of supervised practitioners and the right to refuse such supervised care.

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PAYMENT POLICY

Ohio Medicaid Patients: Not required to pay anything at the time of visit *unless* you agree to a procedure that Medicaid does not cover. We will advise you of this in advance. It is your responsibility to bring your current card *every time* you receive our services.

Medicare Patients: You are required to pay your co-pay and/or deductible at the time of visit. You will also be asked to pay for any procedure that Medicare does not cover. We will advise you of this in advance. Please bring your Medicare card prior to your first visit. You are eligible to apply for the Sliding Fee Discount Scale in order to possibly receive a lower co-pay or nominal fee.

Insurance Patients: You are required to pay your deductible and/or co-pay prior to your visit. You may want to call your insurance company to verify if your claim will be processed "in network" or "out of network." If you cannot pay this amount, please schedule an appointment with the Biller to arrange a payment schedule. Please bring your insurance card to your visit. You are eligible to apply for the Sliding Fee Discount Scale in order to possibly receive a lower co-pay or nominal fee.

Patients Without Coverage: You are encouraged to speak with the Biller or designated Front Desk staff and bring in your current financial documentation. At that time, you will be placed on a sliding fee scale (according to the Federal Poverty Guidelines). Based on your household income, you will be responsible for a nominal fee or up to 100% of your bill. Payment is expected prior to service. *FAILURE TO PROVIDE ACCURATE FINANCIAL INFORMATION WILL RESULT IN DISCHARGE.*

PATIENT POLICIES/GUIDELINES

Prescriptions/Refills: You must be seen and evaluated by a provider so we have a medical record established prior to prescribing any medication. Family Health Care reserves the right not to refill certain medications without seeing the patient in our office. If you need assistance with the cost of your medications, there are programs available. Accessing those programs requires information and cooperation from you. Please let us know if you need to access the Drug Assistance Program.

Test Results: The provider will be ordering and reviewing all of your diagnostic tests. We will notify you of all of your test results by phone, mail, web-portal or a follow-up appointment.

Appointments: We understand that you may need to be seen for an acute illness and will make every effort to meet that need. We currently offer some walk-in acute appointments daily, so please call the office to find out what time. We also keep some appointments open daily for non-urgent appointments. If you feel that your condition requires emergency care, you should go to the nearest hospital with emergency services. Please bring a list of your medications, dosages, and allergies with you to each appointment. Also, any paperwork, insurance or medical cards, change in medical coverage, or income that may affect your cost of healthcare.

After Hours: As your healthcare provider, we understand that you may need medical assistance during the hours the health center is closed. Our providers are on call for medical emergency advice. Please do not call the on-call number for appointments, prescription refills, or any non-emergent situations. If you feel you are in need of emergent evaluation, please go to the nearest hospital with emergency services.

Effective 3/29/2007
Revised 9/24/2018

Family Health Care

Sliding Fee Discount Patient Information

Patients with household income up to and including 200% of the Federal Poverty Guidelines may apply for the Sliding Fee Scale Discount.

1. Any patient may apply for a Sliding Fee Discount by filling out the Sliding Fee Scale Application.
2. Signage will be posted that a Sliding Fee Discount is available to all qualifying patients.
3. The patient must also present one or all of the following:
    a. Salary and wages – Tax Return (1040) or 2 check stubs from current employer or copy of telefile worksheet with confirmation number.
    b. Letter from employer, or Form 4506-T (if W-2 not filed).
    c. Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business or the previous year's tax return.
    d. Social Security/ Disability/Pension – Statement from agencies
    e. Unemployment- Notice of unemployment compensation eligibility or determination of unemployment compensation benefits
    f. Workers compensation – Statement from agency
    g. Child Support – Statement from Child Support Enforcement Agency
    h. Pension – Statement
    i. Any Other Income – written proof
4. The combination of family income and number of dependents determines the adjustment percentage on the sliding fee scale.
5. The Sliding Fee Scale has at least 4 income brackets starting at 100% and up to and including 200% of Federal Poverty Guidelines. .
6. A Sliding Fee Scale Policy will be given to the patient before filling out the sliding fee scale application. The Sliding Fee Scale Application will be signed by the patient and initialed by the Biller or designated Front Desk Staff and filed in the patient's chart along with the proof of income.
7. Patient will have 30 days from date of service to bring in income verification. If income verification is not received with in those 30 days, a statement will be sent to the patient for the full charge amount. If after 60 days from date of service, income verification is still not brought in, patient will be expected to pay 100%.
8. A new Sliding Fee Scale Application can be requested if there is a change in income. Otherwise, the sliding fee scale needs to be completed annually.
9. For the purpose of income determination, a Family is defined as a group of two or more persons related by birth, marriage, adoption, guardianship or household of individuals.
10. A nominal fee payment will be requested at the time of each office visit for medical, dental, clinical pharmacy and behavioral health services. If a patient has both a medical and behavioral health visit on the same day, the behavioral health fee can be waived as long as the medical fee is paid.
11. Financial Hardship Applications are available if the patient requests the nominal fee be deferred or if there is refusal to pay (if a patient presents saying they cannot pay due to no available funds). Patients will be seen by the provider, however, are required to complete the Financial Hardship Application at date of service.
12. Patient agrees to pay to Family Health Care all insurance proceeds received by the patient for services provided by Family Health Care.
13. Services not covered under the Sliding Fee Scale: Vaccines, non-routine medical supplies, medical labs, dental labs, and any outside services. The provider will go over extra costs when a treatment plan is established at the time of visit. Patient will then be billed for these additional costs.

Family Health Care

Sliding Fee Discount Application

It is the policy of Family Health Care to provide health care services to patients in need. Discounts are offered to members of households with combined income of less than double the Federal Poverty level. If you prefer not to provide this information, please sign the following waiver and return this form to the front desk. Thank you.

Waiver:

I choose **not** to provide the following information at this time. **I am waiving my right** to any sliding fee discount to which I may otherwise be entitled.

Patient Name (Please print)	Signature of Patient or Guarantor	Date

Application:

In order to determine the percentage for which you qualify, please complete the following information and return to the front desk.

 # OF PEOPLE SUPPORTED BY THE HOUSEHOLD INCOME BELOW (Please List):

First Name	MI	Last Name	Birth Date	Relationship	Patient? Y/N

Note: Include income from all people in the household and from all sources, including wages, tips, Social Security, disability, pensions, annuities, veteran payments, military, self employment, alimony, child support, unemployment, public aid, and any other income from any other source. Supporting documentation is required before the Sliding Fee Discount can be approved, and approved discounts will be valid for up to one year. **Acceptable forms include: copies of two recent checks/stubs, W-2, recent tax return, public assistance or Social Security check/stub or letter of award, Medical Assistance or Dept. of Social Services Certification Letter, proof of Governmental Assistance, or proof of zero or limited income.**

Total Household Income (Please Complete Only one Column):

Member	Annual	Monthly	Bi-Weekly	Weekly
Self				
Spouse				
Children				
Relatives/others				
Total				

Certification:

I certify that the household size and income information shown above is correct. **I understand that the documentation supporting my household financial position is required before my discount can be approved.** I understand that I must update this information if my situation changes, and that a new Discount Application must be completed at least every twelve (12) months. I have received information explaining the program and I understand and agree to abide by the terms. **I understand that if I am a self –pay patient, I will be asked to pay a nominal fee of $20 (medical), $5 (behavioral health), $5 (clinical pharmacy) and $35 (dental) prior to receiving any health care services.** I understand that by signing below I acknowledge that the information I have provided is honest and up to date information**. I understand that Family Health Care has the right to discharge me as a patient if I have falsely provided information in regards to my household and its income**.

Patient Name (Please Print)	Signature of Patient or Guardian	Date

Office use only

Documentation	%	Date
Received/Reviewed		