Welcome to North Country Primary Care

- We are a level 3 NCQA-recognized Patient Centered Medical Home; see our brochure for details on this.

- We have a patient portal which allows you to access your personal health information 24 hours a day and 7 days a week. You can request appointments, prescription renewals as well as send email messages, saving you the time of making a phone call.

- If you take daily medications, please bring them with you to your appointments. The nurse will review your medications with you during your visit time.

- Call us first! We save time every day in our schedules for sick patients. Please let us know as early in the day as possible when you need our services so we can schedule you for a visit.

- Please call us as soon as possible when you’re unable to keep a scheduled appointment. This allows us to use that time for another patient.

- Please arrive 15 minutes early for your appointment. This allows the nurse to complete the nursing portion of your visit and will allow you more time with your provider.

- We try to stay on schedule, but we also will spend whatever time is necessary to evaluate your problem and that puts us behind schedule at times.

- Co-payments are due at the time of your visit, unless prior arrangements have been made. Also, please bring your insurance card with you.

- Patients and staff can have allergies. Please don’t wear heavy perfumes or heavy scents as that might cause problems for others.

- If you are ill, please request a mask from our receptionist. This helps protect other patients and staff from getting sick with the same illness.

<table>
<thead>
<tr>
<th>Barton/Orleans</th>
<th>Newport</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinic Hours</strong></td>
<td><strong>Clinic Hours</strong></td>
</tr>
<tr>
<td>8 a.m. to 5 p.m.</td>
<td>7:30 a.m. to 5 p.m.</td>
</tr>
<tr>
<td>Monday, Tuesday, And Friday</td>
<td>Wednesday</td>
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<tr>
<td><strong>Phones</strong></td>
<td><strong>Phones</strong></td>
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<tr>
<td>8 a.m. to 4:30 p.m.</td>
<td>Monday - Friday</td>
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<tr>
<td>Monday, Tuesday And Thursday</td>
<td>8 a.m. to 6 p.m.</td>
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<tr>
<td>Friday</td>
<td>8 a.m. to 4:45</td>
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<tr>
<td>8 a.m. to 4:30 p.m.</td>
<td>Friday</td>
</tr>
<tr>
<td>Newport</td>
<td>Barton / Orleans</td>
</tr>
<tr>
<td>186 Medical Village Drive</td>
<td>488 Elm Street</td>
</tr>
<tr>
<td>Newport, VT 05855</td>
<td>Barton, VT 05822</td>
</tr>
<tr>
<td>Phone# 802-334-3520</td>
<td>Phone 802-525-3539</td>
</tr>
<tr>
<td>Fax 802-334-3512</td>
<td>Fax 802-525-3088</td>
</tr>
<tr>
<td>Charles LaGoy, DO</td>
<td>Robert Hawkins, DO</td>
</tr>
<tr>
<td>Tracy Neilan, FNP</td>
<td>Patrick Heaney, PA-C</td>
</tr>
<tr>
<td>Megan Batchelder, MD</td>
<td>David Bourgeois, MD</td>
</tr>
<tr>
<td>Vivian Calobrisi, PA-C</td>
<td>Megan Garrigan, PA-C</td>
</tr>
<tr>
<td>Jessica Andrews, MD</td>
<td>Maria Fatigati, MD</td>
</tr>
<tr>
<td>Catherine Lawrence, FNP</td>
<td>Christopher Rickman, MD</td>
</tr>
<tr>
<td>Rachel DiSanto, MD</td>
<td>Richard Edelstein, MD</td>
</tr>
<tr>
<td>Rory Carr, FNP</td>
<td>802-334-3526</td>
</tr>
</tbody>
</table>
PATIENT REGISTRATION FORM
(Please print clearly)

LAST NAME: ______________________   FIRST NAME: ________________ MI: _____    MAIDEN NAME: _______________________

DATE OF BIRTH: _________________ SEX: _____ MALE _____ FEMALE    SOC. SEC.#: ___________________________

RACE: __ American Indian or Alaskan Native ___ Asian ___ Black or African American ___ White ____ Refused to Report
ETHNICITY: ___ Hispanic or Latino ____ Non Hispanic or Latino ____ Refused to Report
Self-Identified Race/Ethnicity: _______________________________________ (Please specify)

LANGUAGE PREFERRED: __________________ MARITAL STATUS: ___________________________

IF CHILD, PARENT(S)/LEGAL GUARDIAN(S) NAME: __________________________________________
RELATIONSHIP: __________________

MAILING ADDRESS: ________________________________________________________________

PHYSICAL (911) ADDRESS: _______________________________________________________

TEMPORARY/SEASONAL ADDRESS (IF APPLICABLE): _______________________________________

HOME PHONE: __________________ WORK PHONE: __________________ CELL PHONE: _____________

PREFERRED METHOD TO CONTACT YOU: HOME WORK CELL OTHER: _______________________

EMAIL ADDRESS: _________________________________________________________________

CAN WE SEND YOU AN INVITATION TO JOIN OUR PATIENT PORTAL, WHICH ALLOWS YOU TO
ACCESS YOUR PERSONAL HEALTH INFORMATION 24 HOURS A DAY, 7 DAYS A WEEK, REQUEST APPOINTMENTS, REQUEST PRESCRIPTION RENEWALS AND
SEND/RECEIVE SECURE MESSAGES? ___________ YES ___________ NO

NAME OF EMPLOYER: __________________________________ TELEPHONE: _____________________

PRIMARY INSURANCE: ___________________________ POLICYHOLDER: ____________________ DOB: _____________

INSURANCE ID#: _______________________________ GROUP#: ____________________________

SECONDARY INSURANCE: ________________________ POLICYHOLDER: ____________________ DOB: _____________

INSURANCE ID#: _______________________________ GROUP#: ____________________________

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT FOR SERVICES NOT COVERED BY INSURANCE:

PHONE: __________________

DO YOU HAVE A PREFERENCE FOR YOUR PRIMARY CARE PROVIDER? _____________________________

Patient, Parent or Legal Guardian Signature: _______________________________ Date: ________________

Rev. 3/2014
Permission for Disclosure of Medical Information
(Please print clearly)

Today’s Date: ______________________

LAST NAME: ______________________  FIRST NAME: ________________ MI: _____  MAIDEN NAME: ______________________

DATE OF BIRTH: ____________ ___________

MAILING ADDRESS:_____________________________________________  ____________  ____________  ____________

PREFERRED METHOD TO CONTACT YOU:  HOME   WORK   CELL   OTHER: ________________________________

HOME PHONE: __________________  WORK PHONE: __________________  CELL PHONE: __________________

In order to protect your privacy, please help us know the contact person(s) you allow us to talk to. Please list your emergency contact first. **If this is a minor child, please provide the names and information of all parents and guardians.**

<table>
<thead>
<tr>
<th>NAME</th>
<th>PHONE NUMBER</th>
<th>RELATIONSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Contact:</td>
<td></td>
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</tbody>
</table>

Can we leave a message on an answering machine:  YES  NO
Can we leave a message with a person who answers the phone:  YES  NO

List any information that you do not want released or person(s) to whom you do not want us to give your information to:

If this is a minor child, is anyone not allowed to access the child’s records or information?  YES  NO
If yes is circled, please specify below and provide a copy of the court order specifying such.

Patient, Parent or Legal Guardian Signature: _________________________________  Date: ____________

Rev 03/2014, 06/2014, 04/2015
This is a confidential record. Information will not be released without your written permission.

Name: ____________________________________________ Date of Birth: ______________________

Physician or Provider: ________________________________ Date of Exam: ______________________

**Current Medical Problems**

Include current symptoms and active health problems

_________________________________________________________________________________

_________________________________________________________________________________

**Past Medical History**

List all previous hospitalizations and surgeries. (Please include approximate date)

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Indicate if you have had any of the following conditions. Include age/year of occurrence. Give details at the end of this form, if needed.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Age/Year</th>
<th>Condition</th>
<th>Age/Year</th>
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</thead>
<tbody>
<tr>
<td>Asthma</td>
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<td>Hepatitis</td>
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<td>COPD</td>
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<td>Gall Bladder</td>
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<td></td>
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<td>Disease</td>
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<td>Tuberculosis</td>
<td></td>
<td>Cancer</td>
<td></td>
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<tr>
<td>High Blood Pressure</td>
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<td>Seizures</td>
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<tr>
<td>Heart Attack</td>
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<td>Migraines</td>
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<tr>
<td>Blood Clots</td>
<td></td>
<td>Depression</td>
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<tr>
<td>Stroke</td>
<td></td>
<td>Rheumatic Fever</td>
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<tr>
<td>Anemia</td>
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<td>Arthritis</td>
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<td>Lupus</td>
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<td>Diabetes</td>
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<td>Thyroid Disease</td>
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<td>Kidney Stones</td>
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<tr>
<td></td>
<td></td>
<td>Kidney Disease</td>
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<td>Menopause</td>
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<td></td>
<td></td>
<td>Eating Disorder</td>
<td></td>
</tr>
</tbody>
</table>
Family Medical History

<table>
<thead>
<tr>
<th>Relative</th>
<th>Age (or deceased)</th>
<th>Health Problems (or cause of death)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>________________</td>
<td>________________________________</td>
</tr>
<tr>
<td>Mother</td>
<td>_________________</td>
<td>________________________________</td>
</tr>
<tr>
<td>Sister(s)</td>
<td>_________________</td>
<td>________________________________</td>
</tr>
<tr>
<td>Brother(s)</td>
<td>_________________</td>
<td>________________________________</td>
</tr>
</tbody>
</table>

What diseases run in your family? _________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Social History

Employment ________________  Industrial Exposures (asbestos, granite, dust, etc.) ________________
Marital Status _______________  Who lives at home with you? _____________________________________
Do you feel safe at home? ______ Have you been threatened or hurt? __________________________
Hobbies __________________________  Religious Affiliation, if any _____________________________
Primary Language Spoken __________ Do you require an interpreter? ____________________________

Reproductive History

Are you sexually active? ________ What form of birth control do you use, if any? ________________
Other sexual issues or concerns? ____________________________________________________________

WOMEN:

At what age did you have your first period? _______ When was your last period? ________________
Do you have difficulty with your periods? _______ What kind? _________________________________
How many pregnancies (total)? _______ How many children alive? ______________________________
How many miscarriages or abortions? _______ Difficulties with pregnancy? _______________________
Do you do self breast exams? _______________ Do you have routine mammograms? ______________
When was your last mammogram? ____________ When was your last Pap Smear? ________________

MEN:

Do you perform self testicular exams? _______ Do you have routine prostate checks? _______
Problems with testes, prostate, impotence or infertility? ________________________________
**Allergies**

Please list any allergies you may have to medications, pets, environmental, etc.

______________________________  ________________________________

______________________________  ________________________________

**Immunizations**

- Last Tetanus Booster __________  Hepatitis B Series ______________
- Pneumonia Vaccine ____________  Influenza Vaccine(s) ______________

**Medications**

List all medications with dose and frequency. Include non-prescription medications (aspirin, vitamins, etc.)

**IMPORTANT:** There are potential risks and side effects of long-term narcotic treatment. If you are currently taking a controlled substance, we cannot guarantee this will be continued once establishing with your new primary care provider. This will be determined once your new primary care provider has reviewed your records and made an assessment of your current medical needs.

☐ Check here if no medications

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**Health-Related Habits**


Have you ever smoked? ________ What year did you quit? ______________

Do you drink or have you ever drank alcohol? _____ What kind? ________

Number of drinks per week: __________

Do you use or have you ever used recreational drugs? _____ What kind(s)? __________

How often? ________________

Caffeine? ____________ Coffee, tea, cola or other? _________ Amount per day: _______________

Do you follow a special diet? _______ What kind? ________________ Do you take calcium? __________

Do you see a dentist regularly? ______ Who? ________________ Date of last visit? ______________

Do you see an eye doctor regularly? ______ Who? ________________ Date of last visit? ______________

Do you wear corrective lenses/contacts? ______

Is your vision adequately corrected with your current corrective lenses/contacts? __________

Do you have a hearing deficit? ________ Do you wear hearing aids? ______________

Do you have a living will? _________ Do you have a durable power of attorney? __________

**If yes, please bring in a copy.**

Do you wear seat belts? ____________ Do you wear a bike helmet? ______________

Have you ever been physically, sexually or emotionally (verbally) abused? __________
Review of Symptoms

In the last 6 months, have you had any of the following symptoms or difficulties? Check only the ones you have experienced and explain details at the bottom of this page.

___ Change in vision  ___ Constipation  ___ Swollen lymph glands
___ Other eye problems  ___ Urinary frequency  ___ Night sweats
___ Loss of hearing  ___ Urinary incontinence  ___ Frequent headaches
___ Sinus problems  ___ Pain with urination  ___ Fainting
___ Frequent or chronic cough  ___ Sexual difficulties  ___ Convulsions or seizures
___ Shortness of breath  ___ Weight gain  ___ Numbness/loss sensation
___ Chest pains or pressures  ___ Weight loss  ___ Dizziness
___ Palpitations or fluttering  ___ Change in energy level  ___ Tremors
___ Change in appetite  ___ Fatigue or weakness  ___ Depressed mood
___ Difficulty in swallowing  ___ Intolerance to heat/ cold  ___ Change in sleep patterns
___ Frequent heartburn  ___ Excessive thirst  ___ Difficulty tolerating stress
___ Abdominal pain/ bloating  ___ Change in skin color  ___ Thoughts of suicide
___ Change in stools  ___ Swelling of feet or ankles  ___ Racing thoughts
___ Blood in stools  ___ Joint pains or stiffness  ___ Memory loss
___ Black or tarry stools  ___ Muscle weakness  ___ Confusion
___ Diarrhea  ___ Easy bruising  ___ Nervousness or anxiety

ADDITIONAL NOTES

This is a confidential record. Information will not be shared without your written permission.
Protected Health Information Release Authorization

Full Name: __________________________________ Date of Birth: ___________________________

This will authorize _____________________________________________________________ to disclose my protected health information to North Country Primary Care Newport/Barton/Orleans as described for the following purpose: Transfer of care/coordination of care / sharing care for seasonal residents / 

Other:__________________________________________________________________________

Dates of care include: ___________________ to ___________________ or __________________ All dates

Check all that apply:

☐ Discharge Summary ☐ Laboratory Data
☐ History & Physical ☐ E.R. Record(s)
☐ Operative Note(s) ☐ E.K.G. (s)
☐ Consultation(s) ☐ Nurses Note(s)
☐ Progress Note(s) ☐ Other: ___________________
☐ X-Ray, Scans, etc.

☐ All Records (exceptions noted below)

The information regarding the following areas of treatment will not be released without specific authorization, signified by initials.

_____ Mental Illness (excluding psychotherapy notes) _____ HIV related illness
_____ Drug or alcohol treatment * _____ AIDS

* Federal Confidentiality Law - 42 CFR Part 2 prohibits those receiving information on drug or alcohol treatment from re-disclosing it unless written consent is granted by the patient or otherwise permitted by 42 CFR Part 2.

- I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
- I understand that I MAY REFUSE TO SIGN THIS AUTHORIZATION. I also understand that North Country Hospital shall not refuse to treat me if I refuse to sign this authorization.
- I understand that this authorization may be revoked in writing and delivered to _____________________ at any time, although the revocation will not be effective to previously released protected health information pursuant to a valid authorization.
- I understand that if I authorize disclosure of protected health information, the recipient may further disclose this information, and may no longer be protected by federal rules.
- I understand that North Country Hospital shall have the opportunity to obtain compensation in the nature of ___________________________________________ as [(describe)] (third party)

______________________________ __________________________
Date Signature of individual or representative

______________________________
Authority or relationship of representative
(Attach copy of documentation of authority)

EXPIRATION DATE: This authorization will expire on (no later than one year from today) _____________ (If no date is stated, this authorization expires six months from the date it was signed.)
COPY PROVIDED: The patient will be provided a copy of this authorization.
TO THE RECIPIENT OF THIS AUTHORIZATION AND INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal law. This authorization does not permit further disclosure without patient authorization.
AUTHORITY: This form is designed to comply with CFR 45 Sec. 164.508, regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Rev 3.2014
CONSENT TO CARE
I am presenting myself as a patient to North Country Hospital and Health Center, Inc., which includes North Country Hospital and its affiliated clinics (hereinafter “NCH”). I voluntarily consent to such health care as may be validly ordered or recommended by any authorized physician or other medical professional. This care may include laboratory tests, x-rays and other diagnostic procedures and medical treatment. I acknowledge that NCH cannot guarantee the effect of such examination or treatment.

RELEASE OF INFORMATION
I consent to the release from my medical records by my insurance carrier or medical professional responsible for my care of such information as may be necessary. This may include electronic access to my medication history information which may include insurance benefits, eligibility and formulary information, prescribing provider and pharmacy, medication history, as well as prescription refill and renewal information. I also consent to NCH’s use and disclosure of such information necessary to carry out treatment, receive payment, or carry out health care operations as described in the NCH Joint Notice of Health Information Practices. I acknowledge receipt of the Joint Notice of Health Information Practices.

TELEMEDICINE HEALTH SERVICE
I further agree and give my consent to participate in a telemedicine health service, including telemedicine services provided by Dartmouth-Hitchcock providers who will be identified to me before services are rendered, if recommended for my care and treatment. During the telemedicine health service, details of my health information, including medical history, examinations, and diagnostic tests, will be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. Such technology is subject to the following security measures: encryption and HIPAA compliance. Non-medical technical personnel may be present in the area where telemedicine is being performed. I understand there are limitations to the technology and the process of telemedicine, including the potential for incomplete exchange or loss of information, interruptions, and technical difficulties. I understand that the medical records of my telemedicine health services provided by Dartmouth-Hitchcock providers will be maintained by North Country Hospital, but may also be stored in the Dartmouth-Hitchcock electronic medical record. If I need copies of these records, I should follow North Country Hospital’s ‘Notice of Privacy Practices’ to request copies of the records from North Country Hospital.”

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS
I hereby agree to direct payment and benefits payable to me to NCH to cover outstanding balances. If I have no insurance or coverage is denied, I understand that I am financially responsible to NCH for the payment of my account in full.

TERMS OF PAYMENT
I understand and agree to the following payment terms:

- All accounts are due when and as billed, unless prior payment arrangements are made with the business office.
- Should my account be referred for collection, I shall be liable for all costs of collection, including reasonable attorney’s fees and/or collection expenses.

FOR MEDICARE PATIENTS ONLY
AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release of any information needed to act on this request. I request that payment of authorized benefits be made in my behalf. I assign payment for the unpaid charges of the physician(s) for whom NCH is authorized to bill in connection with its services.

(Authorization must be signed by the patient, or by an authorized person in the case of a minor or when patient is physically or mentally incompetent.)

You are entitled to a copy of this agreement at any time. Keep it to protect your legal rights.

_________________________        Signature ____________________________________
Patient Printed Name                  Patient or Authorized Person
Date____________________________          Printed Name__________________________
 Authorized Person/Relationship to Patient

This consent is valid for a period of one year from execution unless sooner revoked by patient or authorized patient representative.

725 consent to hospital care 07/00, 11/17/06, 04/16/09, 01/04/12, 03/23/12, 11/13/13, 05/09/16
Notice of Health Information Practices

Electronic Exchange of Your Health Information

Your health information is electronic, which makes it faster and easier to share. We use your health information as explained in this Notice to Operate Our Health Care Facility and to give you better services. This Notice applies when we or our service providers create, receive, use, or disclose your health information.

What is Health Information?

Health information is information that identifies you and relates to your past, present, or future physical or mental health or condition and the provision of health care to you.

What does North County Hospital have to do with your health information?

North County Hospital is responsible for ensuring the health information practices outlined in this Notice. North County Hospital is a provider of health care services, and is governed by Laws 601.5, 379.292, 379.293, and 379.590. This Notice applies to all providers who receive health information related to you.

How we may use and disclose your health information?

We use or disclose health information to provide you with health care services and treatment. We use or disclose health information about you to carry out activities necessary to run our practice, such as financial matters.

Notice of Health Information Practices

Updated: June 27, 2017

January 1, 2006

Electronic Exchange of Your Health Information

Our Responsibilities

We are required by law to maintain the confidentiality of your health information. We will not use or disclose your health information other than as described below unless you authorise us to do so.

Your Rights and Responsibilities

You have certain rights with respect to your health information. You may inspect and copy your health information, request an amendment to your health information, request that we limit how your health information is used and disclosed, and request that we communicate with you in a manner that is confidential.

Accessing your health information

You have the right to access your health information. If you request access to your health information, we will make it available to you as requested.

Amending your health information

You have the right to request an amendment to your health information. If you request an amendment, we will consider your request. You will not be charged for a request to amend information unless the request is frivolous or malicious.

Communicating in a format that you can understand

You have the right to request that we communicate with you in a format that is accessible to you. For example, you may request that we communicate with you in Braille or sign language.

Right to request restrictions

You have the right to request that we restrict the use and disclosure of your health information for treatment, payment, or operations. We will make every reasonable effort to accommodate your request. However, we are not required to agree to your request.

Right to request confidentiality protections

You have the right to request confidentiality protections when your health information is disclosed to a health plan for payment or health care operations purposes.

Right to request that North County Hospital not contact you

You have the right to request that North County Hospital not contact you at a certain location or to use only electronic communications when sending health information to you. We will accommodate such requests if it is not inconsistent with law.

Right to request a privacy policy

You have the right to request a copy of this Notice at any time. Although we may change our Notice, any changes will not apply to information we already maintain about you or to any disclosures we have already made about you.

If you have questions about this Notice, please refer to it carefully. You may be able to obtain the information you need and ask questions without contacting North County Hospital directly.

North County Hospital

189 Powry Drive/Newton, VT 05855/802.344.7331

When coming runs deep.

North County Hospital
Company Hospital

We are concerned about your safety and health.

You have a right to know about the operation of medical equipment used in your treatment. You have a right to be told about the risks and benefits of any treatment. You have a right to know about the side effects of any medications you are taking. You have a right to know about any medical errors that have been made in your care. If you have any questions about your care, you have a right to ask them.

We encourage you to ask questions about your care. We want you to be an active participant in your healthcare.

We both want to make sure your care is the best it can be.

The U.S. Department of Health and Human Services encourages you to ask questions about your care.

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Our Role as Your Healthcare Team

- Provide you with your choice of healthcare provider
- Partner with you in all healthcare decisions
- Help you set your own self-management goals and action plans
- Coordinate your care with healthcare providers within and outside our office
- Connect you with social support resources in the community
- Use evidence-based guidelines and education to promote wellness and manage acute or chronic conditions
- Respond to your healthcare needs in a timely manner
- Provide the healthcare you need regardless of your insurance coverage

8/2014

Your Healthcare Team

Your healthcare team includes:
- You and your family
- Your healthcare provider
- Nurses
- Office staff
- Care coordinator
- Medical Social Worker
  Helps if you/family are in a crisis, need support in dealing with life changes, to arrange counseling for mental health and/or substance abuse needs, apply and understand safety net services such as housing, food stamps, and transportation, and other services.
- Asthma Self-Management Educator
- Dietician/Certified Diabetic Educator
- Certified Navigators
  Help you understand and apply for health insurance choices available.

Be Part of the Team!

- Write down your concerns and questions and bring them to your appointment
- Bring all of your medication bottles, including over the counter medications, to each appointment
- Let us know at your appointment if you need prescription refills
- Tell us when you visit other healthcare providers; tell other healthcare providers to be sure to share important health information about you with us
- Partner with us to make good choices and develop healthy habits
- Let us know before your visit if you need interpreter services
- Give us your feedback on the patient satisfaction survey or use the suggestion box in the waiting area
Call Us First

- For common illnesses when you or a family member looks or acts sick
  - Fever
  - Flu
  - Sore throats, coughs

- For problems that need care now
  - Infections
  - Continued Vomiting
  - Minor injuries

- Annual physicals, immunizations and well child visits

- For evidence-based information on Self-Management activities such as weight management, exercise programs, and quitting smoking.

Visit our webpage at [www.nchsi.org](http://www.nchsi.org) for information about our practice and links to reliable health information. Also, ask us about Follow My Health, our patient portal which provides requests for on-line medication refills, appointments and many other services.

Newport
Charles LaGoy, DO
Tracy Neilan, FNP
Christopher Rickman, MD
Jessica Andrews, MD
Vivian Calobrisi, PA-C
Megan Batchelder, MD
Catherine Lawrence, FNP
Rachel DiSanto, MD
Rory Carr, FNP
John Lippmann, MD
Naomi Badger, FNP
Umair Malik, MD
Patrick Anderson, PA-C

Phone: (802) 334-3520
Fax: (802) 334-3512

Newport Office Appointment Hours:
Monday, Tuesday & Thursday
7:40 am - 6:00 pm
Wednesday 8:00 am – 6:00 pm
Friday 7:40 am - 5:00 pm

Barton / Orleans
Robert Hawkins, DO
David Bourgeois, MD
Christie Aldrich, FNP
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Phone: (802) 525-3539
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Barton/Orleans Office Appointment Hours:
Monday, Tuesday,
Friday 8:00 am - 5:00 pm
Wednesday 7:30 am – 5:00 pm
Thursday 7:00 am – 5:00 pm

We have after hours (nights & weekends) coverage through the physician on call. Please call North Country Hospital at 802-334-7331; your call will be answered by the hospital operator and directed to the physician on call. Your call will be returned within 1 hour, so leave a number where you can easily be reached.

✅ We know you and your personal health history.

✅ We coordinate care between our office, hospital, and specialists.

✅ We guide you through the often confusing healthcare system.

✅ We partner with you to manage your chronic conditions such as diabetes, asthma and/or heart disease.