North Country Primary Care
Where caring runs deep. Newport • Barton • Orleans

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.

Barton			Newport	
Clinic Hours		Phones	Clinic Hours	Phones
Mon, Tues, Fri	8 a.m. to 5 p.m.	8 a.m. to 4:30 p.m. Monday - Friday	Mon, Tues, Thurs 7:40 to 6 p.m.	Mon - Thurs 8 am. to 4:45 p.m.
Wednesday	7:30 a.m. to 5 p.m.		Wednesday 8 a.m. to 6 p.m.	
Friday	7:00 a.m. to 5 p.m.		Friday 7:40 a.m. to 5 p.m.	Friday 8 a.m. to 4:30 p.m.

Barton
488 Elm Street
Barton, VT 05822
Phone 802-525-3539
Fax 802-525-3088
Robert Hawkins, DO
Patrick Heaney, PA-C
David Bourgeois, MD
Christie Aldrich, FNP
Megan Garrigan, PA-C

Newport
186 Medical Village Drive
Newport, VT 05855
Phone 802-334-3524
Fax 802-334-3512
Charles LaGoy, DO
Tracy Neilan, FNP
Megan Batchelder, MD
Vivian Calobrisi, PA-C
Jessica Andrews, MD
Catherine Lawrence, FNP
Rachel DiSanto, MD
Rory Carr, FNP
Umair Malik, MD
Patrick Anderson, PA-C
John Lippmann, MD
Naomi Badger, FNP
Maria Fatigati, MD
Mandy Degre, FNP
Christopher Rickman, MD
Elizabeth Hartman, FNP
Robert Trembley, MD
Peter Harris, MD

Richard Edelstein, MD **802-334-3526**

PATIENT REGISTRATION FORM

(Please print clearly)

LAST NAME: ______________________ FIRST NAME: ________________ MI: _____ MAIDEN NAME: ________________________
(Legal) (if applicable)

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? __________________________________

North Country Primary Care

Where caring runs deep. Newport • Barton • Orleans

North Country Primary Care Newport
186 Medical Village Dr
Newport, VT 05855
Phone: 802-334-4120/802-334-3520
Fax: 802-334-4123/802-334-3512

North Country Primary Care Barton Orleans
488 Elm Street
Barton, VT 05822
Phone: 802-525-3539
Fax: 802-525-3088

Permission for Disclosure of Medical Information

(Please print clearly)

Today's Date: ____________________

LAST NAME: ____________________ (Legal) FIRST NAME: ______________ MI: _____ MAIDEN NAME: ____________________ (if applicable)

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.**

NAME	PHONE NUMBER	RELATIONSHIP
Emergency Contact:		

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: ____________

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Health Questionnaire

This is a confidential record. Information will not be released without your written permission.

Name: ______________________ Date of Birth: ______________

Physician or Provider: ______________________ Date of Exam: ______________

Local Pharmacy: ______________________ Location: ______________

Mail Order Pharmacy: ______________________

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.

	Age/Year		Age/Year		Age/Year
Asthma	________	Hepatitis	________	Arthritis	________
COPD	________	Gall Bladder Disease	________	Lupus	________
Tuberculosis	________	Cancer	________	Diabetes	________
High Blood Pressure	________	Seizures	________	Thyroid Disease	________
Heart Attack	________	Migraines	________	Kidney Stones	________
Blood Clots	________	Depression	________	Kidney Disease	________
Stroke	________	Rheumatic Fever	________	Menopause	________
Anemia	________			Eating Disorder	________

Family Medical History

Relative	Age (or deceased)	Health Problems (or cause of death)
Father	______________	______________________________________
Mother	______________	______________________________________
Sister(s)	______________	______________________________________
Brother(s)	______________	______________________________________

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

Do you use tobacco? ________ What form? _________ Daily amount? ___________ How long? _______
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
___ Other eye problems
___ Loss of hearing
___ Sinus problems
___ Frequent or chronic cough
___ Shortness of breath
___ Chest pains or pressures
___ Palpitations or fluttering
___ Change in appetite
___ Difficulty in swallowing
___ Frequent heartburn
___ Abdominal pain/ bloating
___ Change in stools
___ Blood in stools
___ Black or tarry stools
___ Diarrhea

___ Constipation
___ Urinary frequency
___ Urinary incontinence
___ Pain with urination
___ Sexual difficulties
___ Weight gain
___ Weight loss
___ Change in energy level
___ Fatigue or weakness
___ Intolerance to heat/ cold
___ Excessive thirst
___ Change in skin color
___ Swelling of feet or ankles
___ Joint pains or stiffness
___ Muscle weakness
___ Easy bruising

___ Swollen lymph glands
___ Night sweats
___ Frequent headaches
___ Fainting
___ Convulsions or seizures
___ Numbness/loss sensation
___ Dizziness
___ Tremors
___ Depressed mood
___ Change in sleep patterns
___ Difficulty tolerating stress
___ Thoughts of suicide
___ Racing thoughts
___ Memory loss
___ Confusion
___ Nervousness or anxiety

ADDITIONAL NOTES

This is a confidential record. Information will not be shared without your written permission.

Return to:
186 Medical Village Dr.
Newport, VT 05855
Phone: 802-334-3520
Fax: 802-334-3512

488 Elm Street
Barton, VT 05822
Phone: 802-525-3539
Fax: 802-525-3088

Protected Health Information Release Authorization

Full Name: ______________________ Date of Birth: ______________

This will authorize ______________ Phone: ____________ City/State: ____________

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

☐ **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)
_____ Drug or alcohol treatment *
_____ HIV related illness
_____ 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

______________ from ______________ as a result of this authorization.
(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 12.2016

North Country Hospital
Where caring runs deep.

189 Prouty Drive|Newport, VT 05855|802.334.7331

Patient Name ______________________ **Date** ______________

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.

189 Prouty Drive | Newport, VT 05855 | 802.334.7331

Notice of Health Information Practices

January 1, 2008,
revised June 25, 2013

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.

If you have questions you may contact:

North Country Health Systems
189 Prouty Drive
Newport, VT 05855
ATTN: Privacy Officer

Notice of Health Information Practices

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, which we refer to as your health or medical record, is an essential part of the health care we provide for you.

Your health record contains personal health information, the confidentiality of which is protected under both state and federal law, and by the safeguards we have in place to protect and secure it. Understanding how we expect to use and disclose your health information helps you to ensure its accuracy, better understand who, what, when, where, and why your health care providers and others may access your health information, and make more informed decisions when authorizing disclosure to others.

Part or all of your medical record is in an electronic form, not on paper. That information is available to any provider or employee who has access to our electronic record keeping system, following our confidentiality policies.

Electronic Exchange of Your Health Information

In some instances, we may transfer health information about you electronically to other health care providers who are providing you treatment or to the insurance plan providing payment for your treatment. Your health information may also be made available through the Vermont Health Information Exchange ("VHIE"). The VHIE is a health information network operated by VITL, Inc. and your treating health care providers may only access your health information through the VHIE if you have provided specific written consent for their access, unless you are in need of emergency treatment. For information about the VHIE, see www.vitl.net.

Your Health Information Rights

Under the Federal Privacy Rules, you generally have the right to:

- Receive notice of the uses and disclosures we expect to make of your health information. You may elect to receive this notice electronically, but you are also entitled to receive a paper copy upon request.
- Request additional restrictions on uses and disclosures of your health information. We are not required to agree to any such request, with the exception of a request to limit disclosures to a health plan if you have paid for the health services provided at the time of service.
- Request that we send you confidential communications by alternative means or at alternative locations.
- Inspect and obtain a copy of your health record.
- Request that your health record be amended.
- Obtain an accounting of disclosures of your health information made without authorization for purposes other than treatment, payment, or health care operations for a time period no longer than six years.
- Receive notification from us following a breach of your health information.

Some of these rights are subject to exceptions and restrictions according to Federal Rules.

We require a request to inspect and copy to be in writing. We reserve the right to restrict requests to normal business hours with an appointment, if necessary. We also reserve the right to use the time allotted by law to comply with your request. Please direct requests to: Director of Health Information Management, 802-334-3265, Email eprice@nchsi.org . If you seek an electronic copy of your electronic health information in a specific electronic form and format that is not readily producible, we will work with you on an alternative form and format.

Our Responsibilities

We are required by the Federal Privacy Rules to:

- Maintain the privacy of your health information,
- Provide you with notice as to our legal duties and privacy practices with respect to health information we collect and maintain about you,
- Abide by the terms of this notice, subject to the following reservation of rights.

We reserve the right to change our health information practices and the terms of this notice, and to make the new provisions effective for all protected health information we maintain, including health information created or received prior to the effective date of any such revised notice. Should our health information practices change, we will post and/or provide a revised notice upon request. We will not use or disclose your health information without your authorization, except as described in this notice.

We May Use and Disclose your Health Information for Treatment, Payment and Health Care Operations

The examples below are given to give you an idea of how information is used.

We will use or disclose your health information for treatment.
For example: Information obtained by a member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In some cases, your information may be reviewed in preparation for care you may need to receive in the future. Information may be disclosed to identified providers who will provide care to you outside of the Hospital.

We will use or disclose your health information for payment.
For example: Employees responsible for our billing process access your information to produce a bill that may be sent to you or your insurance company or health plan. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. Your insurance company may request additional information.

We will use or disclose your health information for health care operations.
Certain uses of health information are necessary for the day-to-day operations of a health care facility. Some physicians and employees not directly involved in your care may see your information as part of their work. For example: medical staff, risk managers, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to improve the quality and effectiveness of the healthcare and service we provide.

Uses and Disclosures That We May Make Unless You Object

Patient List: We maintain a list of current inpatients in the Hospital. If someone inquires about you by name, we will disclose your room number and telephone extension. If you object, preferably in writing, we will not so disclose this information. We also provide a list of religious affiliations available only to clergy. It is, of course, not necessary to indicate such an affiliation.

Family or friends involved in care: Unless you object, preferably in writing, health professionals may, using their best judgment, disclose to a family member, close personal friend, or any other person you identify health information relevant to that person's involvement in your care or payment for that care.

Other Uses and Disclosures

Unless you object, we may contact you to remind you of your appointments, healthcare treatment options or other health services that may be of interest to you (so long as we are not being paid by another organization to do so).

Required Disclosures

The Federal Privacy Rules require us to disclose your personal health information to you at your request, and to the Secretary of Health and Human Services when requested as part of an investigation or compliance review.

Other Disclosures We May Be Required To Make Without Your Authorization

In addition, Federal Privacy Rules permit uses and disclosure of your health information without your authorization including:

- When required by state or federal law. (This includes, but not limited to, required reports to cancer and mammography registries, reports to law enforcement agencies concerning gunshot wounds; reports on illegal alcohol levels tested in the emergency department on a patient involved in a motor vehicle accident.)
- To state and federal public health authorities, including state medical officers, the Food and Drug Administration (FDA), and other agencies charged with preventing or controlling disease.
- To government authorities, including protective service agencies, authorized to receive reports of abuse, neglect, or domestic violence.
- To state and federal government health oversight agencies, such as the U.S. Department of Health and Human Services.
- To the Vermont Board of Medicine.
- When required or court ordered in a judicial or administrative proceeding.
- To law enforcement officials for certain law enforcement purposes, including the reporting of certain types of wounds or injuries, or pursuant to a court order, or for the purpose of identifying or locating a subject, fugitive, material witness, missing person, or victim, provided that the conditions in the rule are met. We will however, make every effort to protect your privacy, if possible.
- To coroners, medical examiners, or funeral directors for purposes of identifying a deceased person or carrying out their duties as required by law.
- To organ procurement organizations for purposes of organ or tissue donation and transplantation, consistent with applicable law.
- For research approved by an Institutional Review Board (IRB) or Privacy Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- When required to avert a serious and imminent threat to health or safety.
- When requested for certain military or national security government functions authorized by law.
- As authorized by law in connection with workers compensation programs.

Uses and Disclosures Specifically Authorized By You

We shall only make other uses and disclosures of your protected health information on the basis of specific written authorization forms signed by you. Specifically, we may not use or disclose your health information for marketing purposes and we may not sell your health information without your written authorization. Additionally, if psychotherapy notes are part of your health information, they may not be disclosed unless you provide written authorization.

You have the right to revoke any such authorization at any time, except to the extent we have already relied on it in making an authorized use or disclosure. If the disclosure is at our request, your authorization is optional, and your treatment will not be affected.

Fundraising

We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. For the same purpose, we may provide your name to our institutionally related foundation. The money raised will be used to expand and improve the services and programs we provide the community. You are free to opt out of fundraising solicitation, and your decision will have no impact on your treatment or payment for services at North Country Hospital

For More Information or to Report a Problem

If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at the address on the front of this brochure or with the Office for Civil Rights, U.S. Department of Health and Human Services, Government Center, J.F. Kennedy Federal Building, Room 1875, Boston, MA, 02203.
Voice: 617-565-1340, Fax: 617-565-3809, TDD: 617-565-1343

Effective Date: September 1, 2013

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

8/2015

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 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
Robert Trembley, 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
Patrick Heaney, PA-C
David Bourgeois, MD
Christie Aldrich, FNP
Megan Garrigan, PA-C

Phone: (802) 525-3539
Fax: (802) 525-3088

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.

12/2016

Call Us First!

- ✓ 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.