North Country Primary Care

Where caring runs deep. Newport • Barton • Orleans

Welcome to North Country Primary Care

- We are an 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 on time 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 Orleans			Newport		
Clinic Hours	7:40 a.m. to 4 p.m.	Monday - Friday	Clinic Hours	7:30 a.m. to 4:15 p.m	Monday - Friday
Phones	8 a.m. to 4:00 p.m.	Monday – Friday	Phones	8:00 a.m. to 4:00 p.m.	Monday – Friday

Newport
186 Medical Village Drive
Newport, VT 05855
Phone 802-334-3520
Fax 802-334-3512

Option 1:
Charles LaGoy, DO
Elizabeth Yasewicz, PA-C
Megan Batchelder, MD
Alexandra Peters, FNP

Mental Health Services
Richard Edelstein, MD
Kelly Hensley, DNP
Phone: 802-334-3526

Option 2:
Patrick Keith, MD
Patrick Heaney, PA-C
Rachel DiSanto, MD
Rory Carr, FNP

Long-term Care
Option 4:
Maria Fatigati, MD

Option 3:
Umair Malik, MD
Cally Hughes, FNP
John Lippmann, MD
Naomi Badger, FNP

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

Robert Hawkins, DO
David Bourgeois, MD
Megan Garrigan, PA-C
Christie Aldrich, FNP
Kirsten Grace, FNP

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PATIENT REGISTRATION FORM

(Please print clearly)

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

DATE OF BIRTH: _____ SEX: ____ MALE ____ FEMALE

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? _____

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New Patient Health Questionnaire

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

Name: _____ Date of Birth: _____

Local Pharmacy: _____ Location: _____Mail Order Pharmacy: _____

** Do you advance directives? _____ Durable power of attorney? _____ COLST: _____
**** If yes, please bring in a copy.**

Current Medical Problems

Include current symptoms and active health problems

_____

_____

_____

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) _____

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

Who lives at home with you? _____

Do you feel safe at home? _____ Have you been threatened or hurt? _____

Have you every been physically, sexually or emotionally (verbally) abused? _____

Are you sexually active? _____ What form of birth control do you use, if any? _____

Other sexual issues or concerns? _____

What is your gender?	**What was your sex assigned at birth?**	**Do you identify as transgender or transsexual?**
□ Female □ Male □ Genderqueer or not exclusively male or female	□ Female □ Male	□ Yes □ No □ Don't know

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 assessed your current medical needs.

IMPORTANT: Also include any medications for opiate use disorder.

☐ 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? _____

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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 or _____ as indicated below

Check all that apply:

- ☒ Discharge Summary **(all within last 2 years)**
- ☐ History & Physical
- ☒ Operative Note(s) **(all within last 2 years)**
- ☒ Consultation(s) **(all within last 2 years)**
- ☒ Progress Note(s) **(all within last 2 years)**
- ☒ X-Ray, Scans, etc. **(all within last 2 years)**
- ☒ Laboratory Data **(all within last 2 years)**
- ☒ E.R. Record(s) **(all within last 2 years)**
- ☒ E.K.G. (s) **(all within last 2 years)**
- ☐ Nurses Note(s)
- ☒ Other: **Problem list, Medications, Allergies**

_____

☐ **All Records** (exceptions noted below)

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

_____ Mental Illness (excluding psychotherapy notes)
_____ Drug or alcohol treatment *
_____ Opiate Use Disorder *
_____ HIV related illness
_____ Hep C

* 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).