Welcome to North Country Primary Care

- **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.

- **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.

- **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.

<table>
<thead>
<tr>
<th>Barton Orleans</th>
<th>Newport</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinic Hours</strong></td>
<td>Monday - Friday</td>
</tr>
<tr>
<td>7:40 a.m. to 4 p.m.</td>
<td></td>
</tr>
<tr>
<td><strong>Phones</strong></td>
<td>Monday – Friday</td>
</tr>
<tr>
<td>8 a.m. to 12 pm and 1:00 pm to 4:00 p.m.</td>
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</tbody>
</table>

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

Megan Batchelder, MD
Elizabeth Yasewicz, PA-C
Andrea Dale, MD
Victoria Martin, PA-C

**Mental Health Services**
Kelly Hensley, DNP
Andrea Van Woert, FNP
Stephanie Amorosa, MD
Rory Carr, FNP

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

John Lippmann, MD
Taylor Galfetti, FNP
Alexandra Peters, FNP
Jared Leavitt, PA-C

Robert Hawkins, DO
Megan Garrigan, PA-C
Carlos Alfaraz, MD
Hailey Bonneau, FNP
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? ________________________________________________
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

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Date of last wellness visit: __________________________________________________________

** 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

<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

Who lives at home with you? _______________________

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

Have you ever been physically, sexually, or emotionally (verbally) abused? ________________________

Gender Identity?

- Female
- Male
- Genderqueer or not exclusively male or female
- Transgender male/trans male/female-to-male (FTM)
- Transgender female/trans woman/male-to-female (MTF)
- Additional gender category or other, please specify
- Choose not to disclose

What was your sex assigned at birth?

- Female
- Male

Sexual Orientation?

- Lesbian or gay or homosexual
- Straight or heterosexual
- Bisexual
- Something else, please describe
- Don’t know
- Choose not to disclose

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

<table>
<thead>
<tr>
<th>MEDICINE NAME</th>
<th>STRENGTH</th>
<th>DOSING</th>
<th>MEDICINE NAME</th>
<th>STRENGTH</th>
<th>DOSING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex. Lisinopril</td>
<td>10 mg</td>
<td>One a day</td>
<td></td>
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</table>

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: __________________

This is a confidential record. Information will not be shared without your written permission.
Permission for Disclosure of Medical Information
(Please print clearly)

Today's Date: __________________________

LAST NAME: ___________________________ FIRST NAME: ___________________________ DATE OF BIRTH: ___________

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

HOME PHONE: __________________________ WORK PHONE: __________________________ CELL PHONE: __________________________

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>
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</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:

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: ___________

☐ Reviewed with no changes Signature: ___________________________ Date: ___________

☐ Reviewed with no changes Signature: ___________________________ Date: ___________

Rev 4/2023
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)      ____ HIV related illness
____ Drug or alcohol treatment *      ____ Hep C
____ Opiate Use Disorder *

* 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 11.2019
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

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.
- Dieticians
- 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
- Sign up for the patient portal for ease of requesting medication refills, appointments and the ability to message your healthcare team
Call Us First

- For common illnesses when you or a family member looks or acts sick
- For problems that need care now
- For 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 our patient portal which provides requests for on-line medication refills, appointments, and many other services.

Newport
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Newport Office Appointment Hours:
Monday – Friday 7:40 am - 4:00 pm

Barton Orleans
Robert Hawkins, DO \( (802) 525-3539 \)
Carlos Alfaraz, MD \( (802) 525-3088 \)
Hailey Bonneau, FNP
Megan Garrigan, PA-C

Barton/Orleans Office Appointment Hours:
Monday - Friday 7:40 am - 4:00 pm

We have after hours (nights & weekends) emergency coverage through the provider on call. Please call North Country Hospital at 802-334-7331; your call will be answered by the hospital operator and directed to the provider 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.

4/2023