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

Thank you for requesting care at North Country Primary Care in our Newport or our Barton Orleans location. Currently, we have limited access for accepting new patients.

- If you already have a PCP, we will ask for the time being you remain with that office and give us a call back in 6 months to see if we're accepting transfers from other offices.
- If you live outside our service area (Orleans and Northern Essex County), reach out to local primary care providers in your area.

All other patients, please complete the attached North Country Primary Care new patient packet, return it to us and if we can accommodate your medical needs, we will mail you a letter with our earliest available appointment with your new provider.

In keeping with our current practice, new pediatric patients, without a current Primary Care Provider, will be accepted in both locations or you can reach out to North Country Pediatrics at 334-3529 to establish care for your child.

Thank you for your understanding.

The staff at North Country Primary Care

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

Charles LaGoy, DO
Megan Batchelder, MD
Elizabeth Yasewicz, PA-C
Victoria Martin, PA-C

Patrick Keith, MD
Patrick Heaney, PA-C
Rory Carr, FNP

John Lippmann, MD

Maria Fatigati,MD

Kelly Hensley, DNP
Richard Edelstein, MD
802-334-3526

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

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

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

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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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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).