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

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.

Barton Orleans			Newport		
Clinic Hours	7:40 a.m. to 4 p.m.	Monday - Friday	Clinic Hours	7:40 a.m. to 4:00 p.m	Monday - Friday
Phones	8 a.m. to 12 pm and 1:00 pm 4:00 p.m.	Monday – Friday	Phones	8:00 a.m. to 12 pm and 1:00 to 4:00 p.m.	Monday – Friday

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

Patrick Keith, MD
Andrea Van Woert, FNP
Stephanie Amorosa, MD
Rory Carr, FNP

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

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

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

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

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? _____

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

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

_____

_____

_____

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

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 ever been physically, sexually, or emotionally (verbally) abused? _____

Gender Identity?	**What was your sex assigned at birth?**	**Sexual Orientation?**
□ 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	□ Female □ Male	□ 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

MEDICINE NAME	STRENGTH	DOSING	MEDICINE NAME	STRENGTH	DOSING
EX. Lisinopril	10 mg	One a day			

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: _____

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

North Country Hospital
Where caring runs deep.

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.**

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:

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

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

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 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).

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

4/2023

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

Megan Batchelder, MD **(802) 334-3520**
Andrea Dale, MD **Fax: (802) 334-3512**
Elizabeth Yasewicz, PA-C
Victoria Martin, PA-C

Patrick Keith, MD
Stephanie Amorosa, MD
Rory Carr, FNP
Andrea Van Woert, FNP

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

Newport Office Appointment Hours:

Monday – Friday 7:40 am - 4:00 pm

Barton Orleans

Robert Hawkins, DO **(802) 525-3539**
Carlos Alfaraz, MD **Fax: (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.

4/2023

Call Us First!

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

- ✓ 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.