NOTCH
NORTHERN TIER CENTER FOR HEALTH
FEDERALLY QUALIFIED HEALTH CENTER

Alburg Health Center
Ph:802-796-4414

Enosburg Health Center
Ph:802-933-5831

Fairfax Health Center
Ph:802-849-2844

Fairfax Pharmacy
Ph: 802-849-2101

Georgia Health Center
Ph: 802-528-2600

NOTCH Administration
Ph:802-255-5560

NOTCH Pharmacy
44 Main Street, Suite 201
Ph:802-255-5530

NOTCH Primary Care
Ph:802-524-4554

Richford Dental Clinic
Ph:802-255-5520

Richford Health Center
Ph:802-255-5500

St. Albans Health Center
Ph:802-524-4554

St. Albans Pharmacy
Ph:802-527-6700

Swanton Health Center
Ph:802-868-2454

Swanton Dental Clinic
Ph:802-868-2454

Swanton Rexall
Ph:802-868-3338

New Patient Checklist - Medical

Required Documents: Complete and return the below four documents to the office:

- ☐ **New Patient Registration Form**
  - This allows us to create your patient chart in our Electronic Medical Record.
- ☐ **Medical History Questionnaire**
  - This allows us to know important information about your health.
- ☐ **Protected Health Information Release Authorization and Consent**
  - This allows us to obtain your medical records from your previous Primary Care Provider.
- ☐ **Consent To Treat**
- ☐ **Therapeutic Relationship Form**
  - This allows us to establish guidelines of what a therapeutic relationship includes.

Optional Documents:

- ☐ **Sliding Fee Application**
  - If you need help paying for your care, please fill out this document and return it to the clinic you are establishing care.
- ☐ **NOTCH Pharmacy Flier**
  - This shows your Notch network pharmacy options and service lines available to help serve your medication needs.
- ☐ **Where To Go and When Handout**
  - If you are unsure when to go to the Emergency Department, Urgent Care, or your Primary Care, this handout will help guide you.
- ☐ **NOTCH Patient Portal Informational Handout**
  - The NOTCH Patient Portal provides real-time access to your health information including sending a message to your Provider, medications, labs, progress notes, and upcoming appointments - whenever you need it.
- ☐ **VITL Health Information Exchange (HIE) Handout**
  - NOTCH Participates in VITL HIE

NORTHERN TIER CENTER FOR HEALTH

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Patient Registration Form

Name (first, last, middle initial): _____ Maiden/Other Name: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Mailing Address (if different): _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____ Work: _____ Ext: _____

Email: _____ DOB: _____ SSN: _____

Sex: ☐ Male ☐ Female

Sex Assigned at Birth: ☐ Male ☐ Female

Sexual Orientation: ☐ Straight or Heterosexual ☐ Lesbian, Gay, or Homosexual ☐ Bisexual ☐ Something Else ☐ Don't Know

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Other

Preferred Pronoun: ☐ He ☐ She ☐ They ☐ We ☐ Other

Race: (Check all that apply) ☐ White ☐ Black/African American ☐ Asian ☐ American Indian / Alaska Native ☐ Native Hawaiian ☐ Other Pacific Islander

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Primary Language: _____ Do you need interpreter services? ☐ Yes ☐ No

Primary Pharmacy: _____ Secondary Pharmacy: _____

Insurance Information: *Please complete the following Insurance information and provide a copy of insurance card(s)*

Primary Medical ☐ Same as patient

Ins Company: _____

ID #: _____ Grp #: _____

Policy Holder Name: _____

DOB: _____ SSN: _____

Primary Dental ☐ Same as patient

Ins Company: _____

ID #: _____ Grp #: _____

Policy Holder Name: _____

DOB: _____ SSN: _____

Secondary Medical ☐ Same as patient

Ins Company: _____

ID #: _____ Grp #: _____

Policy Holder Name: _____

DOB: _____ SSN: _____

Secondary Dental ☐ Same as patient

Ins Company: _____

ID #: _____ Grp #: _____

Policy Holder Name: _____

DOB: _____ SSN: _____

NORTHERN TIER CENTER FOR HEALTH

NOTCH

Patient Registration Form

☐ I have more than two medical insurance carrier

As a Health Center that receives Federal funding, we are required to collect this information. All answers are confidential.

Marital Status: ☐ Annulled ☐ Divorced ☐ Domestic Partner ☐ Legally Separated ☐ Married ☐ Never Married ☐ Widowed ☐ None

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired - Retirement Date: _____ ☐ Self Employed ☐ Active Military ☐ Student ☐ Not Employed

Population Characteristics:

- ☐ I am a migrant dairy worker
- ☐ I am a seasonal migrant worker (non-dairy)
- ☐ I currently rent or own my home (or live with parent/guardian)
- ☐ I currently live in a shelter
- ☐ I currently live in transitional housing
- ☐ I rely on relatives/friends for housing
- ☐ I currently live on the street
- ☐ I live in a hotel or camper
- ☐ I am a US veteran

Person financially responsible, if not the patient – e.g. Parent of a minor child:

Name: _____ Address: _____

Phone: _____ Home/Work: _____ DOB: _____

Name of Person Completing This form (if other than patient): _____

☐ Check here if the person completing this form has legal authority to consent for treatment of the registrant (requires supporting documentation if other than parent of a minor)

Income Information: *Please circle the appropriate family size and corresponding household income range on the table below. All answers are confidential.*

	0-100%				101-150%				151%-200%				Over 200%	
Family Size	**Household Income Range based on Family Size**													
1	$0	to	$15,060		$15,061	to	$22,590		$22,591	to	$30,120		$30,121	& over
2	$0	to	$20,440		$20,441	to	$30,660		$30,661	to	$40,880		$40,881	& over
3	$0	to	$25,820		$25,821	to	$38,730		$38,731	to	$51,640		$51,641	& over
4	$0	to	$31,200		$31,201	to	$46,800		$46,801	to	$62,400		$62,401	& over
5	$0	to	$36,580		$36,581	to	$54,870		$54,871	to	$73,160		$73,161	& over
6	$0	to	$41,960		$41,961	to	$62,940		$62,941	to	$83,920		$83,921	& over

**Add $5,380 per each additional over 6*

NORTHERN TIER CENTER FOR HEALTH
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Medical History Questionnaire

Name:_____ DOB: _____ Today's Date: _____

Height: _____ Weight: _____ Previous Primary Care Provider:_____

Other Care Team Provider (e.g. specialist, out of state providers etc.):_____

Advanced Directive:	Yes	No	Don't Know
Do you have an Advanced Directive? *(if yes, please provide a copy)*	☐	☐	☐
Would you like the Health Center to assist you in developing your Advanced Directive?	☐	☐	☐

Please answer the following questions as best you can, your answers are confidential.

Have there been any major changes to your health within the past year?	☐	☐	☐
If yes, please explain: _____			
Do you have any artificial joints, heart valves, implants, or prosthesis?	☐	☐	☐
Have you had surgery, x-ray treatment, or chemotherapy for a tumor, growth, or other condition?	☐	☐	☐
If yes, please explain: _____			

	Yes	No	N/A
Are you currently pregnant?	☐	☐	☐
If Yes, Due Date: _____			
Are you currently breast feeding?	☐	☐	☐

Health History: *Do you currently have, or have you had any of the following? (Check all that apply)*

- ☐ Addiction
- ☐ Anxiety/Panic Disorder/ PTSD
- ☐ Arthritis
- ☐ Asthma or Shortness of Breath
- ☐ Back or Neck Problems
- ☐ Blood Disease or Anemia
- ☐ Bowel Disease or Ulcers
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Loss of Consciousness
- ☐ Memory Loss
- ☐ Bronchitis or Chronic Cough
- ☐ Cancer or Tumor Location: _____
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fractures, Bone/Joint Deformities
- ☐ Gout
- ☐ Eye Trouble, Injury, or Blindness
- ☐ High Cholesterol
- ☐ Seizures
- ☐ Joint Problems
- ☐ Hernia
- ☐ Gynecological Problems
- ☐ Hearing Loss/ Ringing in Ears
- ☐ Heart Disease or Chest Pain
- ☐ High Blood Pressure
- ☐ Prostate Trouble
- ☐ Liver Disease or Hepatitis
- ☐ Neurological Problems
- ☐ Skin Disease
- ☐ Tuberculosis
- ☐ Trouble Sleeping
- ☐ Thyroid Problems
- ☐ Other: _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

NORTHERN TIER CENTER FOR HEALTH

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Medical History Questionnaire

Name:_____ DOB: _____ Today's Date: _____

Health Screening: *Please note the date of your last screening/occurrence for the following:*

☐ Colonoscopy Date: _____ ☐ PSA _____

☐ Mammogram Date: _____ ☐ Pap Smear _____

Last Menstrual Period Date: _____

Surgical History:

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Family History: *Has anyone in your immediate history experienced the following?*

	Father	Mother	Sibling	Child	
Cancer or Tumor	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	
Heart Disease / Heart Attack	☐	☐	☐	☐	☐ **I do not know my family history**
Mental Health	☐	☐	☐	☐	
Substance Abuse	☐	☐	☐	☐	
Other: _____	☐	☐	☐	☐	

☐ Father Deceased Date of Death: _____ Cause of Death: _____

☐ Mother Deceased Date of Death: _____ Cause of Death: _____

Social History *(Check all that apply)*

☐ Alcohol Use Amount: _____

☐ Drug Use

☐ Smoker

☐ Former Smoker Estimated Quit Date: _____

☐ Chewing Tobacco

☐ Abuse/Neglect

☐ Employed Occupation: _____

☐ Occupational Injury Details: _____

☐ Retired

☐ Living with Spouse

☐ Living Alone

NORTHERN TIER CENTER FOR HEALTH

NOTCH

Medical History Questionnaire

Name:_____ DOB: _____ Today's Date: _____

Allergies:

Medication Allergies / Reaction	Food, Environmental, Animal Allergies / Reaction

Current Medications:

Medication	Dosage	Frequency	Reason for Medication?

Immunizations:

	Yes	No	Don't Know
Date of Last Tetanus Shot: _____ If unknown, was it in the last 10 years?	☐	☐	☐
Have you ever received the pneumovax pneumonia vaccine?	☐	☐	☐
If yes, date vaccine received: _____			

I understand that, to the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health or medications, I will inform my health care provider immediately. I hereby give my consent to treatment for myself, or the named patient (of whom I am the parent, legal guardian, or foster parent) to the Northern Tier Center for Health.

We set aside time just for you. If you're running late or must change an appointment, please call us as soon as possible. Arriving late may require your provider to reschedule your visit to allow enough time for your care. If you miss an appointment, you may have to wait for another opening. By calling us when you are unable to make your scheduled appointment, we are able to see other patients waiting for an appointment.

_____ _____

Signature of Patient or Guardian Date

NORTHERN TIER CENTER FOR HEALTH

NOTCH

Protected Health Information Release Authorization and Consent

Patient's Full Name: _____ DOB: _____

This will authorize (Organization's Name): _____

Address: _____ Phone/Fax: _____

To use or disclose my protected health information to: Northern Tier Center for Health (NOTCH)

Address: Please Select Clinic

AND:

Name: _____ Phone/Fax: _____

Address: _____

As described below for the following purpose(s): ☐ Continuity of Care ☐ Other: _____

Specific Information to be sent:

☐ All Records OR ☐ Diagnostic Imaging Reports ☐ Lab Reports

☐ Dental Records ☐ Consult Notes ☐ Immunizations

☐ Office Notes ☐ Other: _____

☐ Substance Use Disorder Treatment Records provided prior to 2022 (including Medication Assisted Treatment records)

Other (please specify): _____

Dates of care include: _____

Electronic Documentation Received on CD or DVD: *Please send to Richford Health Center – Care Coordination Department 44 Main Street, Ste. 200, Richford, VT 05476*

By Signing below, I authorize release of records and I understand that:

- This authorization may be revoked in writing at any time, although revocation will not be effective as the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
- Information to be released may include treatment related to: substance use disorder treatment and diagnosis, mental health, behavioral health, HIV/AIDS.
- Information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. *Substance use disorder treatment records prior to 2022 are prohibited from redisclosure.

This authorization will expire on: _____

(If no date or event is stated, expiration is one (1) year from date it was signed)

_____ _____

Signature of Individual or Representative Date

_____

Authority or Relationship of Representative

NORTHERN TIER CENTER FOR HEALTH
FEDERALLY QUALIFIED HEALTH CENTER

Consent to Treat

Patient Name: _____ Date of Birth: _____

I hereby give my consent to **Richford Health Center, Inc. dba Northern Tier Center for Health (NOTCH)** to administer medical/dental treatment, local anesthetics and to perform any diagnostic studies necessary.

For those healthcare providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those healthcare providers who have rendered services to me and who accept such assignment. I agree to pay all charges that are not paid in full by assigned insurance.

I hereby authorize Northern Tier Center for Health to obtain medication history, from community pharmacies and/or pharmacy benefit managers for the purpose of continued treatment.

NOTCH Is committed to protecting the confidentiality of patient health information (PHI) per Health Insurance Portability and Accountability Act (HIPAA) regulatory standards. NOTCH employees have a moral and professional obligation to respect confidentiality and protect the security of patient records, while limiting access to PHI to perform their assigned job duties as defined by HIPAA regulatory standards that fall under treatment, payment, and healthcare operations.

_____

Patient/Guardian/POA Signature Date

_____

Patient/Guardian/POA Name

Relationship: ☐ Patient

☐ Legal Guardian **Note this form is not valid until proof of legal guardianship is provided*

☐ POA for Healthcare **Note this form is not valid until proof of POA is provided*

If Legal Guardian / POA

☐ Proof of guardianship/POA for Healthcare received and uploaded to patient chart

☐ Proof of guardianship/POA for Healthcare is on file and was reviewed

Document upload/Review completed by _____ on _____

NORTHERN TIER CENTER FOR HEALTH

Therapeutic Relationship

To have an effective therapeutic relationship with your Provider and Care Team, we want to outline the expectations we have of patients. Non-compliance with treatment plans, disruptive behavior and threats can harm the Provider-patient relationship and can result in us no longer being your Primary Care Provider. We encourage a healthy, trusting relationship that includes discussing any differences, questions, or concerns in a respectful manner. For us to provide the best possible care, the following expectations are required to preserve the relationship with our patients:

- I will comply with my treatment plan and the recommendations developed collaboratively between my Provider and I,
- I will treat my Care Team with dignity and respect,
- I understand profanity, sexual misconduct, physical or verbal abuse, or any other form of violence against anyone will not be allowed or tolerated,
- I understand any instance or threat of physical abuse may be reported to law enforcement,
- I understand if these behavior expectations are not met, I risk being discharged from my Provider's care,
- I understand appointment attendance is critical in maintaining a collaborative relationship and that frequent no-shows may result in us no longer being your Primary Care Provider,
- I understand that this document is effective regardless of signature and will follow me through all NOTCH clinic locations.

Patient Signature:

_____ _____

Print Name Signature / Date

☐ Patient declines to sign Date: _____

NORTHERN TIER CENTER FOR HEALTH

NOTCH Network Pharmacies

Located in

Fairfax	Richford	St. Albans	Swanton
(802)849-2101	(802)255-5530	(802)527-6700	(802)868-3338

WELCOME TO ALL!

Hours by location:

Monday – Friday 8:30-5:30 @ Fairfax, St. Albans & Swanton

Monday 9:00-7:00, Tuesday – Friday 9:00-5:30 @ Richford

Saturday 9:00 – 12:00 – All Pharmacies

Drive-Thru available (Swanton)

Free Mailing Available

Get your medications filled on the same day each month

Pick up a Free Medication Box!

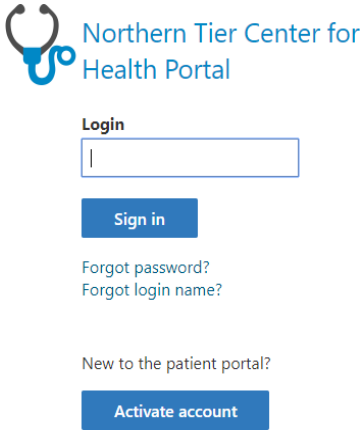
Check out our website→ **www.notchvt.org**

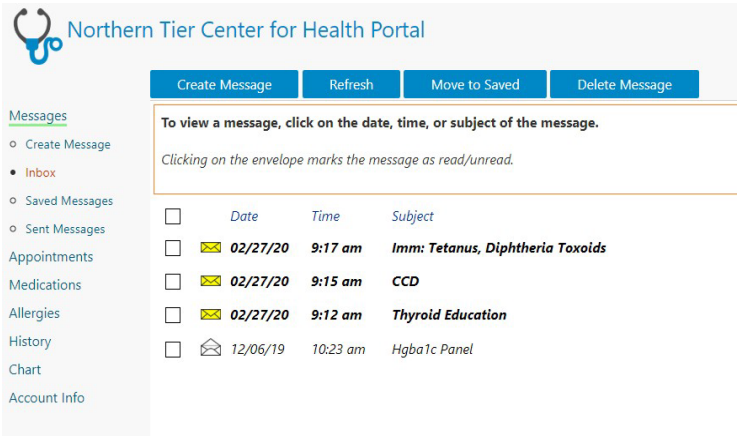
NORTHERN TIER CENTER FOR HEALTH
FEDERALLY QUALIFIED HEALTH CENTER

NOTCH Patient Portal

Manage your health online

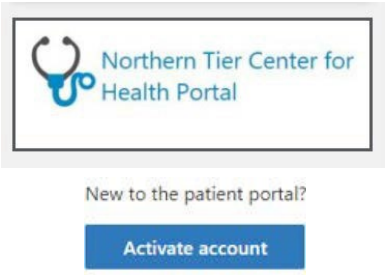
The NOTCH Patient Portal provides real-time access to your health information including medications, labs, progress notes, and upcoming appointments - whenever you need it. You can also request an appointment, medication refills, and message your care team. Signing up is as easy as 1, 2,3...





Step 1: Call the NOTCH Location where you receive your medical care and ask for your portal activation letter; or ask front desk staff when you check in for your next appointment.

Step 2: Go to our website, www.notchvt.org, and click on the link for patient portal. Click on "Activate Account" to start. Complete the form entirely, making sure to enter your last name, first name, and DOB exactly how they appear on your portal activation letter. If you need help, click on the "View a video Tutorial" link at the top of the page.



Step 3: That's it! Navigate through your health information using the links on the left-hand side of the page

- Use the "Messages" link to send or view messages
- Use the "Documents" link to view your progress notes
- Use the "Chart" link to view a chart summary including lab results

The NOTCH patient portal provides secure access to your health information online whenever you need it – Activate your account today!

NORTHERN TIER CENTER FOR HEALTH

Where to Go and When?

Primary Care

- Wellness or preventative visits
- Chronic condition management: (diabetes, heart failure, COPD, asthma, hypertension)
- Vaccinations
- Cold and flu symptoms
- Migraines
- Allergy symptoms
- Skin issues
- Minor fevers
- Earaches/infections
- Pink eye

Call your primary care provider first for a Same-Day-Appointment!

- Sprains and strains
- Cuts that require stitches
- Minor fractures or sprains
- Minor injuries
- Urinary tract infections
- Severe back pain
- Vomiting and diarrhea
- Minor reactions to medications
- Animal bites
- Minor illnesses
- Insect bites/tick bites

If you cannot be seen same day, we may refer you to Urgent Care

Emergency Department

- Chest pain
- Seizures
- Uncontrolled bleeding
- Poison ingestion
- Sudden loss of consciousness or inability to move
- Complex fractures
- Coughing or vomiting blood
- Stroke symptoms
- Difficulty breathing
- Severe abdominal pain
- Head trauma
- Severe asthma attack
- Mental health crisis

Call your primary care provider first, we will guide you! We have a provider on call 24/7 including after hours and holidays!

Vermont
health information exchange

What is this?

So what is the Vermont Health Information Exchange?

The Vermont Health Information Exchange keeps your health records in one secure place. When you see a doctor or healthcare provider who participates, an electronic record may be sent to the Health Information Exchange. This record is ready for the next doctor you see so they know your health history. This doctor adds to your record so it's ready for the next doctor, and so on.

It puts your providers on the same page.

What are my options?

Now that you know more about the Vermont Health Information Exchange, let's talk about your options.

Participate

If you want the benefit of all your providers having your medical record you have nothing to do. If your providers participate, your records will be shared on the Health Information Exchange.

Get more information before you decide

Your doctor or healthcare provider can answer questions about the Health Information Exchange. Or you can call the Health Information Exchange Hotline at **1-888-980-1243**.

Don't participate

You can choose to not have your records shared with providers. This is called opting out. If you opt out, your record will be stored in the Health Information Exchange. But your providers will not be able to see it, except in emergencies.

To opt out, visit **VTHealthInfo.com** to complete or download the opt out form or call the Health Information Exchange Hotline at **1-888-980-1243**.

If you have questions and want to talk to a resource that is independent of the Vermont Health Information Exchange, call the Health Care Advocate Helpline at 1-800-917-7787.

VTHealthInfo.com

For questions, call the Health Information Exchange Hotline at 1-888-980-1243.

Vermont
health information exchange

What's in my record?

Patient records may include:

- Patient demographics (like name, age, date of birth, address)
- Illnesses
- Injuries
- Conditions
- Allergies
- Medications
- Laboratory test results
- Radiology reports
- Patient care summaries
- Doctor notes
- Limited mental health information*
- Limited substance use disorder information* (also called addiction)

** Records about mental health and substance use disorder treatment received at some primary care practices, emergency departments, and hospitals may be included. These records may include diagnoses and prescribed medications. At this time, private psychiatrists, mental health counselors and substance use disorder treatment centers do not contribute to the Vermont Health Information Exchange.*

*For more, visit **VTHealthInfo.com/FAQS***

The Vermont Health Information Exchange is operated by Vermont Information Technology Leaders (VITL) and is funded by the State of Vermont as a service to all Vermonters. For more on VITL, visit ***VITL.net***

What's that mean for me?

Having your doctors and healthcare providers on the same page means better care for you.

When providers use the Health Information Exchange, they have access to a shared record. This means you won't have to answer the same questions everywhere. Or remember when things happened. Or know exactly what kind of medication you've taken. And if you ever can't give your information, like in an emergency, the doctor can still get important information to help you.

VTHealthInfo.com

For questions, call the Health Information Exchange Hotline at 1-888-980-1243.