



Name (first, last, middle initial): _____ Maiden/Other Name: _____
Physical Address: _____ City: _____ State: _____ Zip: _____
Mailing Address (if different): _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Mobile: _____ Carrier: _____ Work: _____
Email: _____ DOB: _____ SSN: _____

Sex: Male/Female
RACE (Select all that apply): ASIAN, NATIVE HAWAIIAN OR PACIFIC ISLANDER, BLACK OR AFRICAN AMERICAN, AMERICAN INDIAN OR ALASKA NATIVE, WHITE, CHOOSE NOT TO DISCLOSE
ETHNICITY: HISPANIC, LATINO/A, OR SPANISH ORIGIN, NOT HISPANIC, LATINO/A OR SPANISH ORIGIN, CHOOSE NOT TO DISCLOSE

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: _____



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

Name: _____ Address: _____

Phone: _____ Home/Work: _____ DOB: _____

Emergency Contact: _____

Marital Status		Are you a U.S. Veteran?	Are you an Agricultural Worker?
<input type="checkbox"/> Annulled	<input type="checkbox"/> Divorced	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Legally Separated	<input type="checkbox"/> No	<input type="checkbox"/> Migratory
<input type="checkbox"/> Married	<input type="checkbox"/> Never Married		<input type="checkbox"/> Seasonal
<input type="checkbox"/> Widowed			
Employment Status		Housing Status	
<input type="checkbox"/> Full Time	<input type="checkbox"/> Self-Employed	Are you Homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Part Time	<input type="checkbox"/> Not Employed	If Homeless, are you:	
		<input type="checkbox"/> Doubling up (living with others)	
		<input type="checkbox"/> Staying in a Shelter	
		<input type="checkbox"/> On the Street	
		<input type="checkbox"/> Living in Transitional Housing	
Student Status			
Are you a student?			
<input type="checkbox"/> Yes			
<input type="checkbox"/> No			

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 check the appropriate box next to family size and corresponding household income range on the table below. As a Health Center that receives Federal funding, we are required to collect this information. All answers are confidential.

Family Size	0-100% Federal Poverty Level		101-150% Federal Poverty Level		151%-200% Federal Poverty Level		Over 200% Federal Poverty Level				
	Household Income Range based on Family Size										
1	\$0	to	\$15,960	\$15,961	to	\$23,940	\$23,941	to	\$31,920	\$31,921	& over
2	\$0	to	\$21,640	\$21,641	to	\$32,460	\$32,461	to	\$43,280	\$43,281	& over
3	\$0	to	\$27,320	\$27,321	to	\$40,980	\$40,981	to	\$54,640	\$54,641	& over
4	\$0	to	\$33,000	\$33,001	to	\$49,500	\$49,501	to	\$66,000	\$66,001	& over
5	\$0	to	\$38,680	\$38,681	to	\$58,020	\$58,021	to	\$77,360	\$77,361	& over
6	\$0	to	\$44,360	\$44,361	to	\$66,540	\$66,541	to	\$88,720	\$88,721	& over

*Add \$5,500 per additional over 6

Effective 1/13/2026



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? <i>(if yes, please provide a copy)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Would you like the Health Center to assist you in developing your Advanced Directive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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? Yes No Don't Know

If yes, please explain: _____

Do you have any artificial joints, heart valves, implants, or prosthesis? Yes No Don't Know

Have you had surgery, x-ray treatment, or chemotherapy for a tumor, growth, or other condition? Yes No Don't Know

If yes, please explain: _____

Are you currently pregnant? Yes No N/A

If Yes, Due Date: _____

Are you currently breast feeding? Yes No N/A

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

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



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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> I do not know my family history
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease / Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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



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:

Date of Last Tetanus Shot: _____ If unknown, was it in the last 10 years? Yes No Don't Know

Have you ever received the pneumovax pneumonia vaccine? Yes No Don't Know

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



Protected Health Information Release Authorization and Consent

Patient Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Information Requested From: _____

Address: _____

Email: _____ Phone: _____ Fax: _____

Information Released To: Northern Tier Center for Health (NOTCH)

Address/Phone/Fax: _____

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

- All Records OR Diagnostic Imaging Reports Lab Reports
- Dental Records Consult Notes Immunizations
- Office Notes Other: _____

Other (please specify): _____

Dates of care include: _____

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

I understand that if I do not state a date of expiration below, then this consent will expire one year from the last date of service to me at the Northern Tier Health Center (NOTCH). I understand that information released may include medical, psychiatric, mental health and/or drug and alcohol records. I understand that my Medical Records are protected under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by state and federal regulations. A photocopy or facsimile of this consent is valid as is the original. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes. You are authorizing the Northern Tier Center for Health (NOTCH) to disclose your records in the following formats: verbal, written, electronic, unless otherwise specified here.

This authorization will expire on: _____

(If no date or event is stated, this release will expire one (1) year from the last visit the patient had)

Patient Signature:

Date

Guardian or Legal Representative Signature

Date

I understand that I may revoke this consent at any time. My decision to revoke this consent will not affect the records that were previously released under this consent. I hereby revoke this consent on: _____ (date). Do not release any further information under this consent.

Signature: _____



Consent for Treatment, Payment, and Healthcare Operations

Patient Name: _____ **Date of Birth:** _____
Please Print Please Print

I. Consent for Treatment:

I hereby give my consent for treatment for myself, or the named patient (of whom I am the parent or legal guardian of and have the legal right to consent to treatment) to the Northern Tier Centers for Health (NOTCH). Treatment may include health screening, diagnosis, medical treatment, dental treatment, mental health, psychiatry services, and drug and alcohol screening, assessment, diagnosis, and treatment.

II. Consent to Release Health Information

I consent to the use within NOTCH and the disclosure to persons or organizations outside of NOTCH of my (or of the named patient for whom I am the parent or legal guardian) medical, dental, Care Quality Interoperative (HIE), Surescripts/Pharmacy, drug and alcohol, mental health, psychiatry and other treatment and health records (“health information”) by NOTCH for the following purposes:

A. Use of health information by or for NOTCH for treatment, payment, and health care operations.

- Providing treatment by NOTCH staff
- Conducting health care operations, including financial or quality assurance audits and / or training.
- Prescription ordering/refilling
- Billing your insurance company directly
- Processing payment for healthcare services, including the disclosure of health records to insurance companies, workers' compensation or liability carriers, or other agencies responsible for payment. This may also include updating insurance information on file with NOTCH.

B. Disclosure of health information to people or organizations outside of NOTCH for treatment purposes:

- NOTCH is authorized to provide all past and present health information including 42 CFR. Part 2 document to other health care providers or agencies who participate in your care. This includes past medical records from outside organizations, prescriptions, drug and alcohol screening, diagnosis, and treatment.
- An individual release of information must be submitted for each transfer of care, family, friends, or other people that you wish to have access to your Medical Record information.

III. Assignment of Benefits

I authorize NOTCH to bill and receive payment directly from Medicare / Medicaid or any other insurance carrier for services provided to me.



I hereby assign to all payments from Medicaid, Medicare, or any health insurance policy for health care, rendered to be me by NOTCH.

I understand I am responsible for any unpaid balances incurred due to my care at NOTCH.

I understand that, to the best of my knowledge, the demographic information I provided is true and correct.

IV. Termination and restrictions of this consent:

- A.** I understand that I may revoke this consent at any time by providing written notice to NOTCH. Revocation will not affect any actions taken by NOTCH in reliance on this consent prior to the date of revocation. Unless otherwise revoked in writing, this consent will expire three (3) years after the date of my last service with NOTCH.

- B.** I understand that I may request restrictions on the use or disclosure of my health information for the purposes described in this consent and that NOTCH may or may not agree to the request. I also understand that except for those restrictions on use or disclosure of health information to which NOTCH agrees, NOTCH will not be able to provide services to me (or the named patient without this signed consent.

- C.** I have read this Consent for Treatment & Consent to the Release of Health Information; I understand and knowingly consent to its content.

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices and understand NOTCH will use my protected health information in accordance with privacy law.

Patient Signature: _____ Date: _____

Parental Signature: _____ Date: _____

Guardian Signature/ POA: _____ Date: _____

If you are a legal guardian/power of attorney of a patient, this document is not valid until legal paperwork is provided.



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...

Northern Tier Center for Health Portal

Login

Sign in

Forgot password?
Forgot login name?

New to the patient portal?

Activate account

Northern Tier Center for Health Portal

Create Message Refresh Move to Saved Delete Message

Messages

- Create Message
- Inbox**
- Saved Messages
- Sent Messages

Appointments

Medications

Allergies

History

Chart

Account Info

To view a message, click on the date, time, or subject of the message.

Clicking on the envelope marks the message as read/unread.

<input type="checkbox"/>	Date	Time	Subject
<input type="checkbox"/>	02/27/20	9:17 am	Imm: Tetanus, Diphtheria Toxoids
<input type="checkbox"/>	02/27/20	9:15 am	CCD
<input type="checkbox"/>	02/27/20	9:12 am	Thyroid Education
<input type="checkbox"/>	12/06/19	10:23 am	Hgba1c Panel

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.

Northern Tier Center for Health Portal

New to the patient portal?

Activate account

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

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



WHERE SHOULD YOU GO?



Primary Care

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



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



NORTHERN TIER CENTER FOR HEALTH
FEDERALLY QUALIFIED HEALTH CENTER

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.