NORTHERN TIER CENTER FOR HEALTH

NOTCH

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: _____

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☐ 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*

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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