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: _____ Carrier: _____ Work: _____

Email: _____ DOB: _____ SSN: _____

Legal Sex	Current Gender	Sexual Orientation	Gender Identity
☐ Male ☐ Female	☐ Male ☐ Female	☐ Straight or Heterosexual ☐ Bisexual ☐ Lesbian, Gay, or Homosexual ☐ Don't Know ☐ Something Else	☐ Male ☐ Female ☐ Transgender Male (Female-to-Male) ☐ Transgender Female (Male-to-Female) ☐ Other
Preferred Pronoun			
☐ He/him ☐ She/her ☐ They/them ☐ Other:			

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
☐ Chinese ☐ Vietnamese ☐ Asian India ☐ Korean ☐ Filipino ☐ Japanese ☐ Other Asian	☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan	☐ 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
☐ Mexican ☐ American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Hispanic, Latino/A, or Spanish Origin ☐ Another Hispanic, Latino/A, and 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: _____

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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?
☐ Annulled ☐ Divorced ☐ Domestic Partner ☐ Legally Separated ☐ Married ☐ Never Married ☐ Widowed	☐ Yes ☐ No	☐ No ☐ Migrant ☐ Seasonal

Employment Status	Housing Status
☐ Full Time ☐ Self-Employed ☐ Part Time ☐ Not Employed	Are you Homeless? ☐ Yes ☐ No If Homeless, are you: ☐ Doubling up (living with others) ☐ Staying in a Shelter ☐ On the Street ☐ Living in Transitional Housing
Student Status	
Are you a student? ☐ Yes ☐ 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.*

	0-100% Federal Poverty Level				101-150% Federal Poverty Level				151%-200% Federal Poverty Level				Over 200% Federal Poverty Level	
Family Size	**Household Income Range based on Family Size**													
1	$0	to	$15,650		$15,651	to	$23,475		$23,476	to	$31,300		$31,301	& over
2	$0	to	$21,150		$21,151	to	$31,725		$31,726	to	$42,300		$42,301	& over
3	$0	to	$26,650		$26,651	to	$39,975		$39,976	to	$53,300		$53,301	& over
4	$0	to	$31,320		$31,321	to	$48,225		$48,226	to	$64,300		$64,301	& over
5	$0	to	$36,700		$36,701	to	$56,475		$56,476	to	$75,300		$75,301	& over
6	$0	to	$42,080		$42,081	to	$64,725		$64,726	to	$86,300		$86,301	& over

**Add $5,500 per each additional over 6*

NORTHERN TIER CENTER FOR HEALTH
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Dental History Questionnaire - Pediatric

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

Parent/Guardian Name: _____ ☐ Parent ☐ Guardian

Previous Dentist: _____ Address: _____ Last Visit: _____

Primary Care Provider: _____ Address:_____ Phone: _____

Your child's overall health and medications he or she may be taking may impact the dental care your child receives. Please answer the following questions completely:

Does your child *(Check all that apply)*:

- ☐ Suck Thumb / Finger
- ☐ Suck / Bite lip
- ☐ Bite / Chew Nails
- ☐ Chew Hard Objects (Pencils, etc.)
- ☐ Grind Teeth
- ☐ Clench Jaws

	Yes	No
Is your child's water fluoridated?	☐	☐
Does your child take fluoride supplements?	☐	☐
Has your child had difficult with dental visits?	☐	☐

How often does your child brush? _____

How often does your child floss? _____

Please list any previous hospitalizations/surgeries, or serious illness: _____

Please list any medications your child is taking: _____

Does your child have a history of allergies / sensitivities / adverse reactions to any drugs or medications (e.g. penicillin, Novocain etc.)? ☐ ☐

If **YES**, please describe: _____

Does your child have a history of allergies to any other substance (latex, environmental, etc.)? ☐ ☐

If **YES**, please describe: _____

Medical History: *Does your child currently have, or has he or she had any of the following? (Check all that apply)*

- ☐ Asthma
- ☐ Cancer
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hemophilia
- ☐ Abnormal Bleeding
- ☐ Tuberculosis (TB)
- ☐ Diabetes
- ☐ Rheumatic Fever
- ☐ Congenital Heart Defect
- ☐ Heart Murmur
- ☐ Convulsions / Epilepsy
- ☐ Stomach, Liver, or Kidney Problems
- ☐ Persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)
- ☐ Other (please list) _____

I understand that, to the best of my knowledge, all of the proceeding answers are true and correct. I hereby give my consent to treatment for the named patient (of whom I am the parent, legal guardian, or foster parent) to the Northern Tier Center for Health.

_____ _____

Signature of Parent or Guardian Date

NORTHERN TIER CENTER FOR HEALTH
NOTCH

Protected Health Information Release Authorization and Consent

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____ Cell phone: _____

Information Requested From: _____ Email: _____

Address: _____ Phone/Fax: _____

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

Address: Please Select a Clinic 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: _____

MEDENT Customers: *Please send by Direct N2N Message - Practice@notch.medentdirect.com*
Electronic Documentation Received on CD or DVD: *Please send to Richford Health Center – Care Coordination Department 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: _____

NORTHERN TIER CENTER FOR HEALTH
FEDERALLY QUALIFIED HEALTH CENTER

Authorization to Treat a Minor Without a Parent/Guardian Present

Northern Tier Centers for Health (NOTCH) requires authorization from the parent or legal guardian of a minor before providing non-emergency medical treatment for injuries or illnesses. This form provides NOTCH and its healthcare providers with your consent to assess and treat your minor child when you are not present.

I, _____, hereby authorize NOTCH and its providers to conduct medical/dental evaluations, diagnostic testing, and treatment for the minor child named below. I affirm that I am the parent and/or legal guardian of this child.

I understand and acknowledge that in my absence, medical and dental care may be rendered to my child without my direct supervision. I have been informed of the nature of the possible treatments and/or procedures listed below and understand the associated risks. I further understand that I am solely responsible for any charges, fees, or expenses related to the services provided.
This authorization is valid from the date of signature until the minor reaches 18 years of age unless revoked in writing prior to that time.

Minor Child's Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

Any care beyond the outlined categories will require a parent or guardian to be present. Extractions and other advanced procedures will only be performed after a direct conversation with NOTCH. Additional consent forms must be signed for advanced treatments.

(Please check all that apply)

- ☐ All treatments
- ☐ Physical examination and/or first aid
- ☐ Medical and nursing management of acute or chronic illness
- ☐ Immunizations (including those required for school)
- ☐ Sports physicals
- ☐ Laboratory testing
- ☐ Dental screenings, cleanings, fillings, and x-rays as needed
- ☐ Treatment for dental pain, infection, or bleeding
- ☐ Administration of medications required for visit

Patient Signature (if applicable): _____Date: _____

Parent Signature: _____ Date: _____

Guardian/POA Signature: _____ Date: _____

*If signing as a legal guardian or power of attorney, legal documentation must be provided for this form to be valid. *

Vermont State Law

State of Vermont Guidelines: Informed Consent Individuals under the 18 years of age are minors under Vermont law [1 V.S.A. § 173]. Therefore, a minor's parent or guardian must provide informed consent for the minor to undergo medical treatment or a procedure with the following **exceptions:**

Minors of any age

- An individual of any age (including minors) may be treated without informed consent in an emergency [12 V.S.A. § 1909(b)].
- Minors of any age may give informed consent to:
    - Medical treatment associated with rape, incest, or sexual abuse. Health care providers are required to report such incidents to the Department for Children and Families within 24 hours [33 V.S.A. § 4911 et seq.].
    - Outpatient mental health treatment, including psychotherapy and counseling services, but not prescription drugs [18 V.S.A. § 8350].
    - Reproductive care, including contraceptive devices, termination of pregnancy, prenatal, delivery, and other pregnancy care [18 V.S.A. § 9493].

Minors 16 years of age and older

- Minors who are 16 years of age and older may consent to donate blood to a voluntary blood donation program where no compensation is received [18 V.S.A. § 9].

Minors 14 years of age and older

- Minors who are 14 years of age and older may apply for voluntary admission to a designated hospital for mental health related evaluation and treatment. Informed consent must be in writing and must include a representation that the person (a) understands that treatment will involve inpatient status, (b) desires to be admitted to the hospital, and (c) consents to voluntary admission without coercion or duress [18 V.S.A. § 7503].

Minors 14 years of age and younger

- Minors under 14 years of age may admit themselves to a hospital for mental health-related treatment by providing their own written informed consent and a written application from a parent or guardian [18 V.S.A. § 7503].

Minors 12 years of age and older

- Minors who are 12 years of age and older may give informed consent to testing and treatment for sexually transmitted diseases including HIV and AIDS, substance use, or substance use disorder. But, if a minor requires immediate hospitalization for treatment of any of these conditions, the parents shall be notified of the hospitalization [18 V.S.A. § 4226]

Confidentiality & Insurance Communications:

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, unless modified by State or other law, a minor who has the authority to consent to a health care service has the same authority to restrict the use and disclosure of the minor's protected health information (PHI) related to that service as if the minor were an adult [45 CFR § 164.502(g)(3)]

The HIPAA Privacy Rule requires that covered entities (including health insurance plans) permit an individual to request that the covered entity restrict uses or disclosures of PHI about the individual to carry out treatment, payment, or health care operations [45 CFR § 164.522(a)(1)(i)(A)]. A health insurance plan may, but is not required to, agree to a requested restriction, except that a health insurance plan must accommodate reasonable requests by individuals to receive communications of PHI from the health insurance plan by alternative means or at alternative locations if the individual clearly states that the disclosure of all or part of that information could endanger the individual [45 CFR § 164.522(a)(1)(ii); 45 CFR § 164.522(b)(1)(ii)]

The above information outlines the basic tenets of a minor's authority to restrict the use or disclosure of the minor's PHI related to a health care service (where the minor has the authority to consent to the health care service without a parent or guardian's consent) and why the minor may therefore request changes to how health insurance plan communications about that service are received. S.37~Amerin Aborjaily~Informed Consent Laws for Minors~4-12-2023.pdf

NORTHERN TIER CENTER FOR HEALTH
FEDERALLY QUALIFIED HEALTH CENTER

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.