RICHMOND
Family Medicine
30 West Main Street
Richmond, VT 05477

Welcome to Richmond Family Medicine

We are pleased that you have chosen to receive your primary medical care with us and look forward to getting to know you.

Richmond Family Medicine is an independent medical practice committed to providing comprehensive, evidence-based, up-to-date and personal primary health services to patients of all ages and genders. We are an accredited Patient-Centered Medical Home. Our approach is to evaluate and understand you as a whole person - your life situation, social support systems and health goals, along with your medical conditions. In this context, we work with each patient to improve health and prevent disease and injury. We work as a clinical team, but you will have one designated primary care clinician for continuity of care and may see other members of the clinical team for acute care appointments.

Our services include:

Preventive care including annual health evaluations for all ages and genders, immunizations, screenings, care for chronic conditions, acute management of illnesses and injuries and psychiatric care. As a primary care team, we coordinate care with specialists and other facilities if needed.

Our Hours:

Monday - Friday 8:00 am to 5:00 pm (by appointment)
Saturday 9:00 am to Noon (for urgent concerns, by appointment)

After hours, an on-call clinician is available to our patients for urgent concerns and can be reached through the answering service by calling the main clinic line at (802) 434-4123.

Appointments:

Please arrive 10 minutes early for appointments. If you are unable to keep an appointment, please call during regular clinic hours and at least 24 hours in advance to cancel or reschedule an appointment.

Bring medications or an up-to-date list of medications and dosages to all appointments.

Understand your insurance coverage and bring your insurance card and any necessary co-pay to your appointment.

Please be advised that opiates, benzodiazepines, and stimulants will not be prescribed at your first visit.

New Patient Questions

We want to make sure that the care you are looking for is within our scope of practice and aligns with our philosophy of medical care. To that end, we would like to learn about the care you seek.

1. Why did you choose Richmond Family Medicine?

2. Have you ever been seen at a Primary Care/Family Practice clinic? If so, why are you no longer a patient there (new to the area, not the right match, PCP retired, other)?

3. What is important to you in your medical care and how can we contribute to your health goals? (medication refills, annual evaluations, help navigating complex medical care, other?)

4. What are your main concerns about your health?

5. Please list any other providers who are important contributors to your health care (specialists, chiropractors, naturopathic physicians, therapists/ mental health clinic

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WHEN YOU SIGN THIS CONSENT TO TREAT FORM, YOU ARE INDICATING YOU HAVE READ, UNDERSTAND AND AGREE TO THE FOLLOWING:

PAYMENT IS YOUR RESPONSIBILITY

As a courtesy to you and to expedite payment, we will be happy to bill your insurance plan if you provide us with accurate insurance details. Please note these details may include personal information for a spouse or parent if they are the subscriber on your plan. A copy of our complete billing and payment policy can be found on our website or in our office.

Other IMPORTANT notes on our billing policy of which you MUST be aware:

- Any co-pays are due when you arrive for your visit.
- Failure to provide 24 hour notice for appointment cancellations will result in a no show fee being assessed.
- If you are discussing a new symptom or an existing medical problem, your bill will include a charge for a problem focused visit, even if that discussion occurs during a preventive annual wellness visit.
- After your insurance company has processed your claim and made payment, we will send a statement for any remaining balance. Payment is due upon receipt of that statement.
- It is **your responsibility to understand what your plan does/does not cover for services and procedures**
- If you are unsure and concerned over whether a service will be covered, we will do our best to assist in that research however **you must ask for assistance BEFORE the service**
- Most bloodwork and other samples are sent to QUEST DIAGNOSTICS for testing. THESE SERVICES ARE BILLED DIRECTLY BY QUEST DIAGNOSTICS

PATIENT CONSENT FORM

The following are IMPORTANT notes regarding our privacy policy of which you MUST be aware:

- You have the right to request a complete copy of our Notice of Privacy Practices (NPP) at any point.
- This NPP policy provides specific guidelines for how we can use and disclose your medical records.
- We will always work diligently to respect and protect the privacy of your personal medical records.
- When it is appropriate and necessary, we provide the minimum necessary information to other groups or individuals. Some specific examples of these appropriate disclosures are:
    - Referrals to specialists
    - Submitting prescription information to a pharmacy
    - Billing and reporting to your insurance carrier
    - Sending bloodwork or other samples to Quest Diagnostics or other testing facilities
    - Immunization records to the state
- Any requested disclosures beyond those deemed appropriate and necessary for your treatment, payment or health care operations will require written consent by you before we can share information.
- Except for emergencies, we will not speak with family members about any aspect of your care unless you have provided us written consent to do so.
- You can also request a personal copy of your medical records at any point; however, a reasonable copying fee may be assessed for this copy.
- With your signature**, you are also giving this office permission to electronically retrieve your prescription record from your pharmacy and other sources, including the Vermont Prescription Monitoring System (VPMS), and Surescripts.**
- With your signature, **you are authorizing our clinical staff to access your medical information from UVM Medical Center's electronic health record, the statewide electronic health record (VHIE), AND the VT State Immunization Registry.**

Patient/Guardian Signature: _____ Date: _____

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing at any point. A copy of our complete privacy policy can be found on our website or in our office.

RICHMOND Family Medicine

NEW PATIENT REGISTRATION FORM

SECTION 1: Patient Information

Legal Name: _____ Nickname: _____

Date of Birth: _____/_____/_____ Gender: _____ Requested Dr/NP: _____

Address: _____ City/St/Zip:_____

Phone #: (_____) _____-_____ Cell #: (_____) _____-_____ Work #: (_____) _____-_____

Email Address:_____

Preferred Pharmacy (name & location):_____

Mail Order Pharmacy (if applicable): _____

Language: _____ *Race:* _____ *Ethnicity:* ❑*Hispanic* ❑*Not Hispanic*

SECTION 2: Guarantor Information

Is someone else responsible for this patient's bill? ❑ Yes ❑ No (If No, skip to section 3)

Guarantor Name: _____Relationship To Patient: _____

Address:_____ City/St/Zip:_____

Phone #: (_____) _____-_____ Cell #: (_____) _____-_____ Work #: (_____) _____-_____

SECTION 3: Insurance Information

Does this patient have medical insurance? ❑ Yes ❑ No (If No, skip to section 4)

Primary Insurance:

Carrier Name & Billing Address:_____

Member ID: _____ Group #:_____Effective Date:____/____/____

Subscriber Name: _____ Relationship:_____ DOB: ____/____/____ Gender: ____

Secondary Insurance:

Carrier Name & Billing Address:_____

Member ID: _____ Group #:_____Effective Date:____/____/____

Subscriber Name:_____ Relationship:_____ DOB: ____/____/____ Gender: _____

SECTION 4: Emergency Contact

Name:_____Relationship To Patient:_____

Phone #: (_____) _____-_____ Cell #: (_____) _____-_____ Work #: (_____) _____-_____

HOW DID YOU HEAR ABOUT US?

_____

RICHMOND Family Medicine

CONSENT TO DISCLOSE HEALTH INFORMATION

I, _____ (_____)
Patient Name (print) *Date of Birth*

Authorize _____ **FAX #** _____
*Name, fax # and address of person/agency **SENDING** information*

To disclose to: _____Richmond Family Medicine_____**FAX #** ___802-434-3130_____
*Name of person/agency **RECEIVING** the disclosure. If not Richmond Family Medicine, specify fax # and address*

The **PURPOSE** of this disclosure is:

❑ I am transferring my medical care ❑ Coordination of care with another medical provider
❑ Legal ❑ Life or other insurance ❑ Other:_____

I would like to disclose the following information:			
❑	My medical record, including a medical summary and detail for the last 3 years and all imaging results, immunizations and growth charts for pediatric patients		
❑	My medical record, including a medical summary and detail for from (____/____/____ through ___/____/____)		
❑	My medical record, including all available records regardless of date		
OR (select all that apply)			
❑	Medications	❑	Progress notes
❑	Test Results	❑	Diagnosis/Problem information
❑	Immunization history	❑	Appointment history
❑	HIV/AIDS Diagnosis & Treatment information	❑	Psychiatric/Mental Health records
❑	Billing/insurance related records	❑	Other

★**Please provide *any exceptions, restrictions or limitations* for this disclosure: (time limits, specific tests, etc.):** ★

_____

_____

This consent to disclose information will expire on: _____. I understand that if I do not note a date or event, then this consent will expire one year from the last date of service to me at the facility. I also understand I have the option to revoke this consent at any point. If revoking consent, please provide today's date here:_____.

I understand that information released may include medical, mental health, and/or drug and alcohol information. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it before I revoked it. A photocopy or facsimile of this consent is as valid as 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 any other purposes. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility from all liability and damage resulting from the lawful release of my protected health information. I also understand that any fees as a result of this request are my responsibility.

_____ _____
Patient Signature Date

_____ _____ _____
Parent, Guardian, Legal Representative Signature (Relationship) Date

Was any assistance provided in completing this form? ❑ Y ❑ N Name of assistant: _____

Summary of assistance provided: _____

ATTENTION FACILITIES SENDING RECORDS TO RICHMOND FAMILY MEDICINE: Electronic records are preferred. Inbound faxes are received in a secure system, directly routed to our EHR. We also are enrolled in the SureScripts Net2Net network.

Richmond Family Medicine ● 30 West Main Street ● Richmond, VT 05477 ● Phone: 802.434.4123 ● Fax 802.434.3130

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY

DATE COMPLETED

BIRTH DATE

AGE

☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ☐ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

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Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition.

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