Thank you for choosing Little Rivers Health Care!
We are a Federally Qualified Health Center that provides care for the whole family.
We're happy to help you navigate the process of becoming a new patient.

First, please complete and return the new patient packet. This includes a health history, insurance and contact information, and information releases from your former providers.

Once we have your completed packet our New Patient Coordinator, Maegan, will then work to get your records from previous providers. This can, unfortunately, take some time. For this reason, we will try to get you scheduled for your first appointment eight weeks after you complete your packet and all necessary releases.

You can help speed the process by encouraging your old providers to quickly send your records.

We welcome your request to see a specific provider, unfortunately we cannot guarantee that that provider will be able to accept you to their panel. We will do our best to match you to the best provider to meet your needs and wishes.

If you have any Questions on the process, please feel free to contact the New Patient Coordinator.

Maegan J. Ballou

(802) 222-3025

Thank you again for choosing Little Rivers Health Care

Special Considerations

- LRHC providers **cannot** sign medical marijuana cards due to our status as a Federally Qualified Health Center
- Our providers will often choose to work with you to taper off of chronic narcotic medications should you be on them when you establish with us due to the evidence regarding their lack of effectiveness for long term pain. This is also true for benzodiazepines due to their risks.
- All of our providers utilize hospitalist services through the hospital of your choice.
- Dr Lessac-Chenen and Dr Griffin deliver babies only at Northern Vermont Regional Hospital in St Johnsbury, VT. Dr Homan, Maureen Boardman, FNP, Ayla Priestly, FPN, Rachel Morse, FNP, and Ally Noble, FNP also provide prenatal care.

- **Primary Care** **Date:_____**
- **Behavioral Health**
- **Psych Med Management**

Pediatric New Patient Contact Sheet

Pick a Clinic : Bradford - East Corinth - Wells River

Provider:_____

Patient Name: _____ DOB:_____

Mailing Address: _____ Telephone: _____

_____

- _____ Date Faxed: _____ Date Received: _____
- _____ Date Faxed: _____ Date Received: _____
- _____ Date Faxed: _____ Date Received: _____
- _____ Date Faxed: _____ Date Received: _____
- _____ Date Faxed: _____ Date Received: _____

Provider Comments:

Insurance-
Pharmacy-
Provider-
Clinic-
Releases-

Hear-

TE-

Pop-up- Immunizations- Insurance Card-

Date Of First Appointment: _____

LITTLE RIVERS HEALTH CARE

Pediatric Registration Form

Little Rivers Health Care, Inc. – A Federally Qualified Health Center
Please check at which clinic you are registering.

- ☐ **Bradford Clinic**
- ☐ **East Corinth Clinic**
- ☐ **Newbury Clinic**
- ☐ **Wells River Clinic**

Patient Information:

Name: (First) _____(Middle)_____(Last)_____DOB:_____
Previous Name(s): _____ Social Security Number _____
Mailing Address: _____
Physical Address if different from above: _____
Home Phone: (_____) _____ Cell Phone: (_____) _____Work Phone: (_____) _____

Would you like access to our online Patient Portal? *

☐ No ☐ Yes, email required _____

* *Vermont has strict guidelines regarding portal access. LRHC needs a written release from the patient over the age of 12 to allow others (parent or guardian) to access the portal. Please ask front desk member for the form.*

How would you like us to remind you of appointments?

- ☐ Phone call (preferred #)_____
- ☐ Text message
- ☐ Email (Please make sure email is listed above)

If unable to reach me:

- ☐ LRHC may leave extended message.
  (Medical and appointment information)
  or
- ☐ LRHC may leave a brief message for return call

Pharmacy Information: Local Pharmacy Name/ Location:_____
Mail Order Pharmacy Name (if applicable): _____

Primary Insurance Information:

Insurance_____Subscriber_____
Group # _____ ID #_____ Effective Date:_____
Relationship to patient: ☐Self ☐Spouse ☐Parent ☐ Other (specify)_____
Are you employed? ☐ Yes ☐ No

Secondary Insurance Information:

Insurance_____Subscriber_____
Relationship to patient: ☐Self ☐Spouse ☐Parent ☐ Other (specify)_____
Group # _____ ID #_____ Effective Date:_____

Responsible Party Information (Who is Responsible for Paying the Bill) – COMPLETE ONLY IF NOT SAME AS PATIENT:

Last Name_____First Name_____Middle Name _____
Address_____City_____State_____Zip _____
DOB _____ Relationship to Patient:_____
Home Phone: (____)_____Work Phone: (____)_____Cell Phone: (____)_____

As a Federally Qualified Health Center, we are required to collect the following information.
We realize this is very personal information but our federal funding is affected by our ability to capture this information.
Please know that your responses will be strictly confidential.

Marital Status:

☐Married ☐Single ☐Divorced
☐Partner ☐Widowed
☐ Legally Separated

Do you have an Advanced Directive?

☐Yes ☐No

Primary Language Spoken:

☐English ☐Spanish
☐Other _____

Will you Need Interpreter Services?

☐Yes ☐No

Race:

☐ White ☐Black/African American
☐ Native Hawaiian ☐Other Pacific Islander
☐ American Indian/Alaskan Native
☐ Vietnamese ☐Asian Indian ☐Other Asian
☐ Chinese ☐Filipino ☐ Japanese
☐ Korean ☐ Guamanian or Chamorro
☐ Samoan ☐ Middle Eastern or North African
☐ Other/Choose not to report

Ethnicity:

☐ Not Hispanic, Latino/a, or Spanish Origin
☐ Another Hispanic, Latino/a, or Spanish Origin ☐ Cuban ☐Puerto Rican
☐ Mexican, Mexican American, Chicano/a

Are you a United States Veteran or on Active duty?

Veteran ☐Yes ☐ No

Are you homeless?

☐Yes ☐ No ☐Choose not to answer

Are you a migrant worker?

☐Yes ☐No

Are you a seasonal worker?

☐Yes ☐No

Gender Identity:

☐ Male ☐Female
☐Transgender- Male (Female-To-Male)
☐Transgender Female (Male-To-Female)
☐Genderqueer
☐Something else, please describe _____
☐Choose Not to Disclose

Do you think of yourself as (check one):

☐Lesbian/Gay/Homosexual
☐Straight/heterosexual ☐Bisexual
☐Something Else ☐Don't know
☐Choose Not to Disclose Legal

Assigned Sex at Birth:

What sex were you assigned at birth on your original birth certificate (While LRHC recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence. If your preferred name and pronouns are different from these, please let us know)

☐Male ☐ Female ☐ Declined to answer

Preferred Pronouns _____

Release of Your Protected Health Information

Little Rivers Health Care is authorized to disclose protected health information as directed below: Please check specific information that is released for each contact listed. ***This authorization shall be in effect until revoked by the patient or authorized representative. If you are the parent/guardian, you must fill in your information below for our office to release information to you.***

Parent/Guardian – Release information to the following person. Additional contacts on page 3. Check all that apply for what purpose(s):

Name: _____ Relationship _____ Phone (____)_____
____ HIPPA contact- LRHC may release all information to the person listed above Phone (____)_____
____Emergency contact

Parent/Guardian – Release information to the following person. Additional contacts on page 3. Check all that apply for what purpose(s):

Name: _____ Relationship _____ Phone (____)_____
____ HIPPA contact- LRHC may release all information to the person listed above Phone (____)_____
____Emergency contact

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Parent/Guardian – Release information to the following person. Additional contacts on page 3. Check all that apply for what purpose(s):

Name: _____ Relationship _____ Phone (____)_____
____ HIPPA contact- LRHC may release all information to the person listed above Phone (____)_____
____Emergency contact

_____ _____ _____
Signature of Patient/Legal Representative Printed Name of Patient/Representative Date

TREATMENT CONSENT, PAYMENT POLICY ACKNOWLEDGEMENT, AND INFORMATION CERTIFICATION

General Consent for Care and Treatment:

I give my consent for Little Rivers Health Care to perform reasonable and necessary medical examinations, testing and treatment in the course of my care. This includes (but is not limited to) routine laboratory work, minor office procedures such as skin tag removal and cryotherapy (freezing) of warts, and administration of medications and vaccines as prescribed by the providers.

I understand that during the course of treatment, health care workers may be exposed to the patient's blood and/or other body fluids increasing their risk of Hepatitis B, Hepatitis C and/or HIV. In the event an exposure occurs, I understand the need for testing for these diseases and I agree to such testing of myself to promote the health and welfare of the health care worker. I understand that this consent will be valid and remain in effect as long as I attend the clinic.

Notification of Privacy

I have been offered a copy of LRHC's Notice of Privacy Practices and understand LRHC may disclose my health information for the purposes of providing and coordinating treatment, conducting health care operations, providing health information and obtaining payment. This consent remains in effect until I notify you and I understand I have the right to withdraw this consent at any time. Doing so will not affect any actions which were taken by LRHC before I withdrew this consent.

Consent to Receive Payment and Financial Policy Acknowledgement:

I authorize Little Rivers Health Care to file claims with my insurance carrier and accept payment for services rendered. I have received a copy of Little Rivers' Payment Policy and understand that I am responsible for any deductibles, co-payments or non-covered service. I understand that my failing to do so may result in my being submitted to collections, reported to the credit bureau, and/or terminated from the services at LITTLE RIVERS HEALTH CARE.

Certification:

I certify that the information I have given is complete and accurate to the best of my knowledge. I understand that failure to provide accurate information may result in termination of services at **LITTLE RIVERS HEALTH CARE** and report of the failure to my insurance company and/or the federal government.

_____ Date: _____

Signature of Patient/Parent/ Guardian (Please Circle One)

****Please note if you are signing the consent as a patient's guardian, we will need to be provided with a copy of the current guardianship decree.**

Child's Name_____ Name of Person Completing: _____

Date Of Birth _____ ☐ M ☐ F Relationship: _____

Is there a custody order: ☐ Yes ☐ No

If yes, please explain: _____

Pediatric Initial History Questionnaire

Please list all individuals living in the child's home:

Name	Relationship	Birth Date	Health Problems

Birth History

Birth Weight: ____lbs. _____oz. How many weeks gestation at birth: _____

Was the delivery: ☐ vaginal? ☐ Cesarean? If Cesarean, why? _____

Did baby have any problems right after birth? ☐ Yes ☐ No

If yes, explain: _____

Did mother have any problems with her pregnancy? ☐ Yes ☐ No

If yes, explain: _____

During pregnancy, did mother:

☐ Smoke ☐ Drink Alcohol ☐ Use Drugs or Medications

Was initial feeding ☐ Breast? ☐ Bottle?

Did the baby go home with mother from hospital? ☐ Yes ☐ No

If no, please explain: _____

General

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

If no, please explain: _____

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

If yes, please explain: _____

Has your child has serious injuries or accidents? ☐ Yes ☐ No

If yes, please explain: _____

Has your child has any surgeries? ☐ Yes ☐ No

If yes, please explain: _____

Has your child ever been hospitalized? ☐ Yes ☐ No

If yes, please explain: _____

Is your child allergic to any medications or drugs? ☐ Yes ☐ No

If yes, please explain: _____

Development

Are you concerned about your child's physical development? ☐ Yes ☐ No

If yes, please explain: _____

Are you concerned about your child's emotional development? ☐ Yes ☐ No

If yes, please explain: _____

Are you concerned about your child's attention span? ☐ Yes ☐ No

If yes, please explain: _____

Is your child in school? ☐ Yes ☐ No

If yes, How is their behavior in school?_____

Have they failed or repeated a grade in school? _____

How are they doing academically? _____

Do they have an IEP and/or in special education classes? _____

Family History

Have any family members had the following:

Deafness ☐ Yes ☐ No Who? _____

Asthma	☐ Yes ☐ No	Who? _____
Tuberculosis	☐ Yes ☐ No	Who? _____
Heart Disease (before 50 years old)	☐ Yes ☐ No	Who? _____
High Blood Pressure (before 50 years old)	☐ Yes ☐ No	Who? _____
High Cholesterol	☐ Yes ☐ No	Who? _____
Anemia	☐ Yes ☐ No	Who? _____
Bleeding Disorder	☐ Yes ☐ No	Who? _____
Liver Disease	☐ Yes ☐ No	Who? _____
Kidney Disease	☐ Yes ☐ No	Who? _____
Diabetes (before 50 years old)	☐ Yes ☐ No	Who? _____
Epilepsy or seizures	☐ Yes ☐ No	Who? _____
Alcohol Abuse	☐ Yes ☐ No	Who? _____
Drug abuse	☐ Yes ☐ No	Who? _____
Mental illness	☐ Yes ☐ No	Who? _____
Mental retardation	☐ Yes ☐ No	Who? _____
Immune problems, HIV or AIDS	☐ Yes ☐ No	Who? _____

Past Medical History

Does your child have, or have they ever had:

Chicken Pox	☐ Yes ☐ No	Comments _____
Frequent Ear Infections	☐ Yes ☐ No	Comments _____
Problems with ears or hearing	☐ Yes ☐ No	Comments _____
Nasal allergies	☐ Yes ☐ No	Comments _____
Problems with eyes or vision	☐ Yes ☐ No	Comments _____
Asthma, bronchitis, bronchiolitis or pneumonia	☐ Yes ☐ No	Comments _____
Any heart problem or heart murmur	☐ Yes ☐ No	Comments _____

Anemia or bleeding problems	☐ Yes	☐ No	Comments _____
Blood Transfusion	☐ Yes	☐ No	Comments _____
Constipation requiring doctor visits	☐ Yes	☐ No	Comments _____
Bladder or kidney infection	☐ Yes	☐ No	Comments _____
Eczema or chronic skin problem	☐ Yes	☐ No	Comments _____
Frequent headaches	☐ Yes	☐ No	Comments _____
Seizures or other neurologic problem	☐ Yes	☐ No	Comments _____
Diabetes	☐ Yes	☐ No	Comments _____
Thyroid or other endocrine problem	☐ Yes	☐ No	Comments _____
Use of alcohol or drugs	☐ Yes	☐ No	Comments _____
(For girls) Started her menstrual period?	☐ Yes	☐ No	Comments _____
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Comments _____

Additional Comments _____

_____

_____

_____

LITTLE RIVERS HEALTH CARE

FY 2025 Household Size and Income Chart

Dear Patient,
We are required to ask for this information in order to continue to receive federal funding. We realize that this is sensitive information and for that reason, it is immediately separated from your other patient information so no connection can be made between you and your family income. Thank you for providing this information.

Instructions:

STEP 2 **On the same line as your family size**- circle the box where your household income falls

	2025 ANNUAL FAMILY INCOME RANGE					
Family Size	A	B	C	D	E	F
1	Under $15,650	$15,807 to $21,752	$21,753 to $23,475	$23,476 to $27,388	$27,389 to $31,300	Over $31,301
2	Under $21,150	$21,362 to $29,396	$29,397 to $31,725	$31,726 to $37,013	$37,014 to $42,300	Over $42,301
3	Under $26,650	$26,917 to $37,041	$37,042 to $39,975	$39,976 to $46,638	$46,639 to $53,300	Over $53,301
4	Under $32,150	$32,472 to $44,685	$44,686 to $48,225	$48,226 to $56,263	$56,264 to $64,300	Over $64,301
5	Under $37,650	$38,027 to $52,330	$52,331 to $56,475	$56,476 to $65,888	$65,889 to $75,300	Over $75,301
6	Under $43,150	$43,582 to $59,974	$59,975 to $64,725	$64,726 to $75,513	$75,514 to $86,300	Over $86,301
7	Under $48,650	$49,137 to $67,619	$67,620 to $72,975	$72,976 to $85,138	$85,139 to $97,300	Over $97,301
8	Under $54,150	$54,692 to $75,263	$75,264 to $81,225	$81,226 to $94,763	$94,764 to $108,300	Over $108,301
Additional	Additional Per Person $5,500	Additional Per Person $7,590	Additional Per Person $8,250	Additional Per Person $9,625	Additional Per Person $11,000	Additional Per Person $11,001

LITTLE RIVERS HEALTH CARE

2025 Sliding Fee Scale Chart

2025 ANNUAL FAMILY INCOME RANGE

Family Size	A	B	C	D	E	F
% Of Poverty Level	100 and Under	101 -138	139 - 150	151 - 175	176 - 200	Over 200
Flat Charge- Medical, BH, Preventative Dental	$0.00	1	$5.00	$7.00	$10.00	Full Fee
Dental- Restorative, Endodontics, Oral Surgery, Prosthetics	10 % of charges	15% of charges	20% of charges	25% of charges	30% of charges	Full Fee
1	Under $15,650	Under $15,650	$15,807 to $21,752	$21,753 to $23,475	$23,476 to $27,388	$27,389 to $31,300	Over $31,301
2	Under $21,150	Under $21,150	$21,362 to $29,396	$29,397 to $31,725	$31,726 to $37,013	$37,014 to $42,300	Over $42,301
3	Under $26,650	Under $26,650	$26,917 to $37,041	$37,042 to $39,975	$39,976 to $46,638	$46,639 to $53,300	Over $53,301
4	Under $32,150	Under $32,150	$32,472 to $44,685	$44,686 to $48,225	$48,226 to $56,263	$56,264 to $64,300	Over $64,301
5	Under $37,650	Under $37,650	$38,027 to $52,330	$52,331 to $56,475	$56,476 to $65,888	$65,889 to $75,300	Over $75,301
6	Under $43,150	Under $43,150	$43,582 to $59,974	$59,975 to $64,725	$64,726 to $75,513	$75,514 to $86,300	Over $86,301
7	Under $47,340	Under $47,340	$47,813 to $65,798	$65,799 to $71,010	$71,011 to $82,845	$82,846 to $94,680	Over $94,681
8	Under $54,150	Under $54,150	$54,692 to $75,263	$75,264 to $81,225	$81,226 to $94,763	$94,764 to $108,300	Over $108,301
Additional Per Person $5,500	Additional Per Person $5,500	Additional Per Person $7,590	Additional Per Person $8,250	Additional Per Person $9,625	Additional Per Person $11,000	Additional Per Person $11,001

Patient Portal Access Form –Accessing a Minor's Records

Patient Information: (Patient's medical record that the portal user will access)

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

Parent/Guardian's Information: (only one user account can be created)

E-mail Address: _____ Telephone: _____

About the Patient Portal –

My Patient Portal is a web-based system that allows you to securely access a patient's medical record from anywhere you can connect to the internet. The portal is encrypted, and password protected. Information that you view is stored in Little Rivers Health Care's medical system (eClinicalWorks) and not on the internet. Once your portal account is activated, you will receive confirmation through the e-mail you provided to us. We will not share information about your e-mail address or password. If at any time you believe that your e-mail account and/or password have been compromised, it is your responsibility to inform us. Your access can also be disabled if you choose to discontinue use of the portal.

I understand the following about My Patient Portal:

- **My Patient Portal is used for NON-URGENT information. If there is an emergency, I WILL CALL 911.**
- Vermont law protects the patient privacy of minors for certain types of treatment. Parents/guardians of children aged birth thru 12 years are eligible to sign up to access the child's medical record. Written permission from the age of 12 and older is required for parent to access a child's portal.
- My portal activation is done through a personal e-mail account; a work email is not recommended.
- Information may not be immediately available.
- Not all entries in a medical record can be viewed.
- Highly sensitive information may be excluded from the portal.
- Messages will be reviewed typically within 1-2 business days.

Age 12 and older:

I give permission for my Parent/Guardian to have:

Restricted Access: ☐

Or

Complete Access: ☐

By signing this form, I give permission for my Parent/Legal Guardian to have access to my online portal. I understand that my Parent/Legal Guardian will be able to contact my provider through portal and have access to my health record. I understand at any time I can revoke access to my Parent/Legal Guardian by notifying my Little Rivers Health Care office.

Patients Signature: _____ **Date:** _____

LITTLE RIVERS HEALTH CARE

AUTHORIZATION FOR RELEASE OF INFORMATION **2024**

HIPAA COMPLIANT RELEASE

Patient's Name:_____ DOB: _____

From:

Facility/Provider:_____

Address/Phone:_____

To*:* **Little Rivers Health Care, Maegan – New Patient Coordinator, 437 S Main St., P.O. Box 318, Bradford, VT, 05033**

I hereby authorize and request the exchange of information between Little Rivers Health Care and the above named individual/organization. The following information is requested to be shared:

□ **All**	□ **Only those items which are pertinent to this referral**	
□ Office Notes	□ Intake Assessment	□ Test Results
□ Psych/Social/Emotional Evaluation	□ Medications	□ Treatment Plan
□ Immunizations	□ Summaries	□ Discharge Summary
□ Counselor Reports	□ Teacher Reports	

Date range of records to release (check one): □ Only documents from _____to_____ □ All dates

Reason for Request_____

Form of Disclosure (check all allowed): □ Written □ Verbal □ Electronic

•Release of confidential information is subject to State and Federal Laws. By signing this release, I acknowledge my permission to release the above information to and/or from the individual or agency I have named which may include drug and alcohol abuse information.

Note: Federal regulations govern the confidentiality of alcohol and drug dependent persons (42CFR Par 2). Federal Law prohibits the disclosure of (1) psychotherapy notes, (2) information compiled in reasonable anticipation, or for the use in civil, criminal, or administration action or proceedings.

•I understand I may revoke this authorization at any time by notifying LITTLE RIVERS HEALTH CARE in writing, except to the extent that: a) action has been taken in reliance on this authorization; or, b) if this authorization is obtained as a condition or obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

•I understand I have a right to request and receive a **Notice of Privacy Practices** for LITTLE RIVERS HEALTH CARE, INC.

•All releases expire one year from the date signed unless otherwise indicated. Optional expiration date: _____

•I hereby authorized the following; (please initial if applicable)

_____Disclosure of the results of HIV antibody blood testing and/or information concerning AIDS (Acquired Immune-Deficiency Syndrome).

_____ _____ _____

Signature of Patient or Patient's Representative Printed Name Relationship

Witness Signature/Printed Name_____ Date:_____

Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

New Patient Coordinator
Phone: 802-222-3025
Fax: 866-939-1476

LITTLE RIVERS HEALTH CARE

AUTHORIZATION FOR RELEASE OF INFORMATION **2024**

HIPAA COMPLIANT RELEASE

Patient's Name:_____ DOB: _____

From:

Facility/Provider:_____

Address/Phone:_____

To*:* **Little Rivers Health Care, Maegan – New Patient Coordinator, 437 S Main St., P.O. Box 318, Bradford, VT, 05033**

I hereby authorize and request the exchange of information between Little Rivers Health Care and the above named individual/organization. The following information is requested to be shared:

□ **All**	□ **Only those items which are pertinent to this referral**	
□ Office Notes	□ Intake Assessment	□ Test Results
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□ Immunizations	□ Summaries	□ Discharge Summary
□ Counselor Reports	□ Teacher Reports	

Date range of records to release (check one): □ Only documents from _____to_____ □ All dates

Reason for Request_____

Form of Disclosure (check all allowed): □ Written □ Verbal □ Electronic

•Release of confidential information is subject to State and Federal Laws. By signing this release, I acknowledge my permission to release the above information to and/or from the individual or agency I have named which may include drug and alcohol abuse information.

Note: Federal regulations govern the confidentiality of alcohol and drug dependent persons (42CFR Par 2). Federal Law prohibits the disclosure of (1) psychotherapy notes, (2) information compiled in reasonable anticipation, or for the use in civil, criminal, or administration action or proceedings.

•I understand I may revoke this authorization at any time by notifying LITTLE RIVERS HEALTH CARE in writing, except to the extent that: a) action has been taken in reliance on this authorization; or, b) if this authorization is obtained as a condition or obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

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Signature of Patient or Patient's Representative Printed Name Relationship

Witness Signature/Printed Name_____ Date:_____

Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

New Patient Coordinator
Phone: 802-222-3025
Fax: 866-939-1476

LITTLE RIVERS HEALTH CARE

AUTHORIZATION FOR RELEASE OF INFORMATION **2024**

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□ **All**	□ **Only those items which are pertinent to this referral**	
□ Office Notes	□ Intake Assessment	□ Test Results
□ Psych/Social/Emotional Evaluation	□ Medications	□ Treatment Plan
□ Immunizations	□ Summaries	□ Discharge Summary
□ Counselor Reports	□ Teacher Reports	

Date range of records to release (check one): □ Only documents from _____to_____ □ All dates

Reason for Request_____

Form of Disclosure (check all allowed): □ Written □ Verbal □ Electronic

•Release of confidential information is subject to State and Federal Laws. By signing this release, I acknowledge my permission to release the above information to and/or from the individual or agency I have named which may include drug and alcohol abuse information.

Note: Federal regulations govern the confidentiality of alcohol and drug dependent persons (42CFR Par 2). Federal Law prohibits the disclosure of (1) psychotherapy notes, (2) information compiled in reasonable anticipation, or for the use in civil, criminal, or administration action or proceedings.

•I understand I may revoke this authorization at any time by notifying LITTLE RIVERS HEALTH CARE in writing, except to the extent that: a) action has been taken in reliance on this authorization; or, b) if this authorization is obtained as a condition or obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

•I understand I have a right to request and receive a **Notice of Privacy Practices** for LITTLE RIVERS HEALTH CARE, INC.

•All releases expire one year from the date signed unless otherwise indicated. Optional expiration date: _____

•I hereby authorized the following; (please initial if applicable)

_____Disclosure of the results of HIV antibody blood testing and/or information concerning AIDS (Acquired Immune-Deficiency Syndrome).

_____ _____ _____

Signature of Patient or Patient's Representative Printed Name Relationship

Witness Signature/Printed Name_____ Date:_____

Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

New Patient Coordinator
Phone: 802-222-3025
Fax: 866-939-1476

LITTLE RIVERS HEALTH CARE

AUTHORIZATION FOR RELEASE OF INFORMATION **2024**

HIPAA COMPLIANT RELEASE

Patient's Name:_____ DOB: _____

From:

Facility/Provider:_____

Address/Phone:_____

To*:* **Little Rivers Health Care, Maegan – New Patient Coordinator, 437 S Main St., P.O. Box 318, Bradford, VT, 05033**

I hereby authorize and request the exchange of information between Little Rivers Health Care and the above named individual/organization. The following information is requested to be shared:

□ **All**	□ **Only those items which are pertinent to this referral**	
□ Office Notes	□ Intake Assessment	□ Test Results
□ Psych/Social/Emotional Evaluation	□ Medications	□ Treatment Plan
□ Immunizations	□ Summaries	□ Discharge Summary
□ Counselor Reports	□ Teacher Reports	

Date range of records to release (check one): □ Only documents from _____to_____ □ All dates

Reason for Request_____

Form of Disclosure (check all allowed): □ Written □ Verbal □ Electronic

•Release of confidential information is subject to State and Federal Laws. By signing this release, I acknowledge my permission to release the above information to and/or from the individual or agency I have named which may include drug and alcohol abuse information.

Note: Federal regulations govern the confidentiality of alcohol and drug dependent persons (42CFR Par 2). Federal Law prohibits the disclosure of (1) psychotherapy notes, (2) information compiled in reasonable anticipation, or for the use in civil, criminal, or administration action or proceedings.

•I understand I may revoke this authorization at any time by notifying LITTLE RIVERS HEALTH CARE in writing, except to the extent that: a) action has been taken in reliance on this authorization; or, b) if this authorization is obtained as a condition or obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

•I understand I have a right to request and receive a **Notice of Privacy Practices** for LITTLE RIVERS HEALTH CARE, INC.

•All releases expire one year from the date signed unless otherwise indicated. Optional expiration date: _____

•I hereby authorized the following; (please initial if applicable)

_____Disclosure of the results of HIV antibody blood testing and/or information concerning AIDS (Acquired Immune-Deficiency Syndrome).

_____ _____ _____

Signature of Patient or Patient's Representative Printed Name Relationship

Witness Signature/Printed Name_____ Date:_____

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New Patient Coordinator
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LITTLE RIVERS HEALTH CARE

HELP US TAKE CARE OF YOU

Carequality and Commonwell Health Information Exchange

Name:_____ DOB:_____

Address:_____

Organization Obtaining Consent: Little Rivers Healthcare

A health information exchange makes your medical records available to other health care providers. This form allows you to give your consent for all of your health care providers to use the exchange for your care for you. Only providers who care for you are allowed to see and use your medical records on the exchange. Medical records may be lab test results and written reports. They may also include mental health and substance abuse treatment records.

- I can choose to give or not give my consent for providers to see and use my medical records from the exchange.
- I know that I will receive care even if I do not sign this form.
- My consent will only end if the exchange stops or if I sign a revocation form.

I give my consent for Little Rivers to access any records available on these exchanges and to use them to provide care, get paid for my care, and for health care operations.

Please initial below:

_____I consent for my health information to be **TRANSFERRED TO** Little Rivers Health Care

_____I consent for my health information to be **TRANSFERRED FROM** LRHC to outside facilities.

_____I consent for my health information to be **BOTH** transferred to Little Rivers Health Care and to be sent to outside facilities

_____I do not wish for my information to be exchanged.

_____ _____

Signature of patient Date

_____ _____

Signature of authorized representative if under 18yo Date

_____ _____

Name of authorized representative Relationship to patient

PAYMENT POLICY 2025

Thank you for choosing Little Rivers Health Care (**LRHC**). Prompt payment for the services that you receive ensures that we can continue to provide you and our community with affordable, quality medical care. The following explains the guidelines and rules of our Payment Policy. **Please read it, and feel free to ask us questions**. A copy will be provided to you upon request.

ABOUT INSURANCE

Little Rivers Health Care (LRHC) participates in most insurance plans, including Medicare and Medicaid. **Your insurance benefit is a contract between you and your insurance company; knowing your insurance benefits and co-pay amount is your responsibility.** You need to contact your insurance company with any questions you may have about your coverage. Please be aware that you might be responsible for the entire amount of the bill if your insurance company does not have a contract with Little Rivers.

Please note the following:

1. **Co-payments must** be paid at the time of service. This arrangement is part **of your contract with your insurance company**. **Failure of LRHC to collect co-payments from patients can be considered fraud**. Please help us in upholding the law, by paying your co-payment at each visit.
2. **If you have an active insurance card**, we will bill your insurance company. If any balance remains, we will bill you.
3. **If you do NOT have an active insurance card, you will be billed for each visit,** until we can verify your insurance coverage.

LRHC accepts personal checks, credit cards, and cash. **If you need financial help to pay your bill**, ask to speak with our care coordinators or our business office, to set up payment options. LRHC offers a **Sliding Fee Scale,** available to income eligible patients. A payment plan can be worked out before you make your appointment.

A 20% discount is applied when a balance is paid in full at the time you receive the service.

OTHER THINGS TO KNOW:

~IF YOUR INSURANCE CHANGES, call us before your next visit. LRHC will make the necessary changes to help you receive your maximum benefits. If your insurance company has not paid your claim in 45 days, LRHC billing department will follow up with your insurance company, to find out why the claim has not processed.

~PROOF of insurance – **LRHC must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. **If you fail to provide the correct insurance information in a timely manner, you will be responsible for the balance of a claim.**

~NON-COVERED services - Please make sure that you know which services are covered by your health insurance. If you receive services at LRHC that are not covered by your insurance plan, you will be responsible for paying for these services.

~CLAIMS submission - LRHC submits your claims and assists you in any way we can to help get your claims paid. You may be asked by your insurance company to supply certain information directly to them, such as more information about when or where an injury happened, if it was work-related, etc. It is your responsibility to supply your insurance company with information that they request from you. **If you are unsure about a request that you have received from your insurance company, you can call one of our care coordinators and they can discuss it with you.** If your claim is not paid because you have not supplied requested information, you will be responsible for paying the claim. Another reason your claim may not be paid by the insurance company is because you have not met your deductible for the year, and the claim will also be your responsibility to pay.

~NONPAYMENT –If your account is over 90 days past due, the following procedure is followed: You will receive a letter giving you 14 days to either pay the balance in full, or make a partial payment, and set up a payment plan with our billing office. Please help us to avoid collections activity. **If you cannot pay your bill, call our care coordinators or billing department as soon as possible, to make arrangements that you can afford.**

HELP US TAKE CARE OF YOU

At Little Rivers Health Care, Inc., we take great pride in providing our patients with the very best health care, at an affordable price. Please help us by following these simple rules:

Co-Pays are due at the time of service

If you have insurance, please bring your insurance card with you. If you have a co-pay, please know how much your co-pay is, and be ready to pay it when you come for your visit. Insurance companies require us to collect the co-pay at the time of service. If you do not pay your co-pay, we cannot continue to make appointments for you.

24 hour notice is needed to cancel or reschedule your appointment

Our schedules are full, and we often have a waiting list for patients to get an appointment. By providing 24-hours' notice, it allows us time to schedule a patient waiting for care.

48 hour notice is needed for prescription refill requests

Please keep track of ALL of your prescriptions. When you need a refill, call us or your pharmacy AT LEAST 48 hours before you run out of your medication, so that we can process the prescription. We DO NOT refill prescriptions after normal business hours or on weekends. Please also understand that some medications can't be refilled without an office visit, blood and/or urine testing, or other lab tests.

Also, please bring all current prescription and over-the-counter medications with you to your visits to LRHC, as well as any supplements you are taking.

If you don't have insurance, we offer a Sliding Fee Scale

Care Coordinators can meet with you in our offices, and help you complete an application for our sliding fee program, as well as applications for Medicaid, Vermont Health Connect, and Ladies First Programs. They know what resources are available in our communities, and how to access them.

Keep your Health Care Up-To-Date

It is important for people of all ages to have regular "wellness visits" with your health care provider. Although you may not require frequent visits to our clinics, health care standards and regulations require us to keep accurate records of our patients. If you have not seen your provider in over three years, you will receive a notice from LRHC, asking if you wish to remain a patient here, and to schedule a wellness visit. If you wish to transfer or stop your care here at LRHC, please let us know.

Contact our office with billing questions

If you get a bill, you can help us by paying it as soon as you can. If you believe there is a mistake with the bill, or you need help understanding it, please contact our billing department at 802-222-5659.

How to Access After-Hours Care

If you are ill outside of our normal business hours, you can reach the provider on-call by calling the office number of your regular clinic and following the prompts in the out-going message to have the on-call provider paged. Please do not use this service for routine prescription medication refills.

By working together, Little Rivers Health Care can continue to provide excellent, affordable, health care to our community. Thank you for giving us the opportunity to serve you.