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**Little Rivers Health Care, Inc. – A Federally Qualified Health Center**

**Please check at which clinic you are registering.**

PO Box 318  PO Box A  PO Box 755

437 So. Main Street 720 Village Road 65 Main Street

Bradford, VT 05033 E. Corinth, VT 05040 Wells River, VT 05081

**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 (email address here if not listed above)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If unable to reach me**: (Please check all that apply)

☐ LRHC may leave medical information

☐ LRHC may leave appointment Information

☐ 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date: \_\_\_\_\_\_/ \_\_\_\_\_\_/ \_\_\_\_\_\_

Relationship to patient:Self Spouse Parent Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Information:**

Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient:Self Spouse Parent Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Relationship to Patient:

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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.***

**Contact #1** – Release information to the following person. Check all that apply for what purpose(s):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Appointment Information (date, time, with whom, and for what) Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Information and results from any tests or X-rays

\_\_\_\_Emergency contact

**Contact #2** – Release information to the following person and for what purpose(s):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Appointment Information (date, time, with whom, and for what) Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Information and results from any tests or X-rays

\_\_\_\_Emergency contact

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

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

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*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 ☐Asian

☐More than one race

☐Other/Choose not to Report

**Ethnicity:**

Are you Hispanic/Latino?

☐Yes ☐ No ☐Choose not to Report

**Are you a United States Veteran or on Active duty?**

Veteran ☐Yes ☐ No

Active Duty ☐Yes ☐ No

**Are you Homeless?**

☐No ☐Yes (If Yes) → ☐Homeless Shelter

☐Transitional

☐Doubling up

☐ Street

☐Other\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 ☐Choose Not to Disclose

**Sexual Orientation:**

☐Lesbian ☐Gay

☐Straight ☐Bisexual

☐Something Else ☐Don’t know

☐Choose Not to Disclose Legal

**Sex:**

☐Male ☐ Female

**Birth Sex:**

☐Male ☐ Female

**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.**

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