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

To disclose to: _____
*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

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ADULT HEALTH HISTORY QUESTIONNAIRE
and
SUMMARY OF CURRENT HEALTH STATUS

NAME: **DOB:**

In completing this form, please be as detailed as possible. The information you provide will give us a comprehensive history of your medical concerns, allowing us to deliver the best care for your specific needs.

REVIEW OF SYMPTOMS: Please check the box for any **persistent** symptoms you have had in the **past few months**.

- ❑ Unexplained weight loss/gain
- ❑ Unexplained fatigue/weakness
- ❑ Fall asleep during day when sitting
- ❑ Skin: New mole/change in mole
- ❑ Skin: Rash/itching
- ❑ Breast lump/pain/nipple disch.
- ❑ Nosebleeds, trouble swallowing
- ❑ Frequent sore throat, hoarseness
- ❑ Hearing loss/ringing in ears
- ❑ Change in vision/eye pain/redness
- ❑ Chest pain/discomfort
- ❑ Fast/irregular heartbeat
- ❑ Cough/wheeze
- ❑ Loud snoring
- ❑ Shortness of breath
- ❑ Heartburn/reflux/indigestion
- ❑ Blood/changes in bowel movement
- ❑ Constipation
- ❑ Leaking urine
- ❑ Blood in urine
- ❑ Increased frequency of urination
- ❑ Penile/Vaginal discharge
- ❑ Concern with sexual function
- ❑ Neck pain
- ❑ Back pain
- ❑ Muscle/joint pain_____
- ❑ Heat or cold sensitivity
- ❑ Swollen glands
- ❑ Easy bruising
- ❑ Headache
- ❑ Memory loss
- ❑ Fainting
- ❑ Dizziness
- ❑ Numbness/tingling
- ❑ Unsteady gait
- ❑ Frequent falls
- ❑ Hay fever/allergies
- ❑ Frequent infections
- ❑ Anxiety/stress/irritability
- ❑ Sleep problem
- ❑ Lack of concentration
- ❑ Problem with menstrual periods

IMMUNIZATIONS: Check off any vaccinations you have had. Add the year, if known.

Tetanus (Td) ❑ With Pertussis (Tdap) ❑ Varicella (Chicken Pox) shot *or* illness ❑ Pneumovax (pneumonia) ❑
Influenza (flu shot) ❑ Hepatitis A ❑ Hepatitis B ❑ MMR ❑ Meningitis ❑ Zostavax (shingles) ❑ HPV ❑

MEDICATIONS: List **ALL** medications you are currently taking. Include prescribed, OTC, vitamins, home remedies, birth control pills, supplements, inhalers, etc. Attach additional pages if more room is needed.

Medication	Dose/Frequency	Medication	Dose/Frequency

ALLERGIES: List any allergies you have, including food, drug, or other sources. Include details on the type of reaction.

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (Cholesterol)	Date:_____	Abnormal?	❑ No ❑ Yes
Colonoscopy	Date:_____	Polyp(s)?	❑ No ❑ Yes
Mammogram	Date:_____	Abnormal?	❑ No ❑ Yes
Pap Smear	Date:_____	Abnormal?	❑ No ❑ Yes
Bone Density Test	Date:_____	Abnormal?	❑ No ❑ Yes

PERSONAL MEDICAL HISTORY: Do you have (current) or have you had (past) any of the following conditions?

Condition	***Current***	***Past***	***Comments***
Alcohol/Drug Abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder/Kidney Problems			
Blood Clots			
Blood Transfusion			
Breast Lump (benign)			
Cancer: Breast			
Cancer: Colon			
Cancer: Other Type			
Cancer: Ovarian			
Cancer: Prostate			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes			
Diverticulosis			
Emphysema			
Fractures (broken bones)			
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			
Gout			
Gynecological Conditions			
Heart Attack			
Hepatitis (Specify Type)			
High Blood Pressure			
High Cholesterol			
Irritable Bowel Syndrome			
Kidney Disease			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate Conditions			
Seizures/Epilepsy			
Skin Conditions (Specify Type)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid Disease			
Other:			
Other:			
Other:			

SURGICAL HISTORY: Please check off any procedure or surgeries. List any abnormal finding or complications.

Procedure	***Year***	***Comments***
Abdominal Surgery		
Appendectomy		
Back Surgery		
Biopsy		
Breast Biopsy		
Breast Surgery		
Colonoscopy		
Coronary Bypass		
Coronary Stent		
EGD (Stomach Endoscopy)		
Cataract		
Gallbladder Removal		
Heart Surgery (other than coronary bypass)		
Hip Surgery		
Hysterectomy		
Knee Surgery		
LEEP (Cervix Surgery)		
Neck Surgery		
Ovary Ligation		
Ovary Removal		
Vasectomy		
Sigmoidoscopy		
Sinus Surgery		
Other (list)		

FAMILY HISTORY: Indicate which relative has had the following diseases. If relative is deceased, indicate cause and year in the comments section. IF YOU ARE ADOPTED AND DO NOT KNOW YOUR FAMILY HISTORY, CHECK HERE: ❑

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	***Comments***
No significant history known									
Alcoholism/Drug Abuse									
Alzheimer's									
Asthma									
Autoimmune Disease									
Bleeding or clotting disorder									
Cancer: Breast									
Cancer: Colon									
Cancer: Other Type									
Cancer: Ovarian									
Cancer: Prostate									
Colon Polyp									
Coronary Artery Disease									
Depression/Suicide/Anxiety									
Diabetes									
Emphysema/COPD									
Genetic Disorder (Please Explain)									
Glaucoma									
Heart Disease									

FAMILY HISTORY: *(Continued)*

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	***Comments***
Hepatitis B or C									
High Blood Pressure/Hypertension									
High Cholesterol									
Hip Fracture									
Hypothyroidism/Thyroid Disease									
Kidney Disease									
Kidney Stones									
Macular Degeneration									
Migraine Headaches									
Osteoporosis									
Other:									
Other:									

SOCIAL HISTORY:

Occupation: _____ Employment Status: _____

Employer: _____ Years of education/highest degree: _____

Marital Status: _____ Spouse/Partner's Name:_____

Number of children: _____ Ages of children:_____ Number of grandchildren:_____

Who lives at home with you?_____

Leisure activities, group involvement, religion, volunteer work, recent travel:_____

_____

_____

WOMEN'S HEALTH HISTORY:

Total # of pregnancies: _____ Number of births: _____

Date (month/day if known) of last menstrual period if you are still menstruating:_____

Age at beginning of periods (menstruation):_____ Age at end of periods (menopause):_____

OTHER HEALTH ISSUES:

Tobacco Use ❑Never ❑No ❑Yes

Former smoker:

Quit date: _____ Smoked for _____ Years

Smoked _____ packs per day.

Current smoker:

I have smoked for _____ years

I smoke _____ packs per day

Other tobacco: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew

❑ Vaping ❑ Other:_____

Alcohol Use ❑Never ❑No ❑Yes

I drink _____(#) drinks/wk ❑Beer ❑Wine ❑Liquor

Drug Use

Do you use marijuana or recreational drugs? ❑No ❑Yes

Have you ever used needles to inject drugs? ❑No ❑Yes

Exercise/Diet: Do you exercise regularly? ❑No ❑Yes

What kind of exercise?_____

How long and how often?_____

How would you rate your diet? ❑Good ❑Fair ❑Poor

Safety: Do you use a bike helmet? ❑ N/A ❑ No ❑ Yes

Do you use seatbelts consistently? ❑ No ❑ Yes

Working CO/Smoke detector in home? ❑ No ❑ Yes

Do you wear sunscreen regularly? ❑ No ❑ Yes

Are guns locked in home? ❑ N/A ❑ No ❑ Yes

Any concerns about your safety? ❑ No ❑ Yes

Do you have an Advance Directive? ❑ No ❑ Yes

Sexual Activity: Are you sexually involved? ❑ No ❑ Yes

Your gender identity? ❑M ❑F ❑Other_____

Sexual partners have been: ❑M ❑F ❑Other_____

Birth Control Method(s):_____