RICHMOND
Family Medicine

How to become a new patient at Richmond Family Medicine:

We are so pleased to welcome new patients into our practice - thank you for choosing us to help you maintain good health! Before you can be seen for your first visit, here are some things you need to know, and some actions you need to take:

- **This is a partnership!** We truly care for our patients, and consider them to be part of our family. We believe we provide the best treatment available in the area. We also expect a lot of our patients - and this is because the best outcomes happen for those patients who are fully engaged in their treatment plan. By designating Richmond Family Medicine as your primary care provider, you are creating a partnership for the management of your health. We ask that all patients read and understand our welcome letter that spells out the expectations of this partnership.

- **We need to know your history!** Access to, and review of, your previous medical records are an absolute necessity to establishing care in our office and making your first appointment. Here's why:
    1) It is potentially unsafe to treat you for any conditions without understanding your medical history - both reported by you AND your previous providers. We simply cannot treat you without this information.
    2) We need to be certain we will be able to meet your needs. We follow strict policies that dictate our diagnosis and treatment behaviors, following nationally recognized medical guidelines. If you are expecting a specific treatment that we are not able to provide, we may decline your acceptance into our practice and make other recommendations for care.

- **You must understand our billing policy!** While we truly believe that high quality medical care is a right and not a privilege, that care comes at a real cost and we expect that patients will ensure payment for all charges incurred in our office. Since most patients have insurance, that means we require patients to provide us with up to date insurance cards, address and contact information, and to pay for any co-pays and outstanding balances at the time of visit. Patients without insurance must pay for services at the time of visit. We offer a 20% discount for these payments. Patients with a history of non-payment at other practices may be declined for acceptance in our office. Please take the time to read our complete billing policy.

- **You will need to complete some paperwork!** The following forms must be completed and submitted to us (by mail, fax, or in person)
    1) New patient registration
    2) Release of records request form(s) - complete one for each of your previous medical providers and/or specialists you've seen

  Additionally, we will need to scan a copy of your insurance card and photo ID into our system to ensure proper identification and prevent spelling or address errors.

- **We don't do "Meet and Greet" visits!** We have a very large panel of patients, and want to ensure we are able to see every patient that needs to be seen for treatment. As a result, we are simply unable to set aside time to meet with potential new patients looking to see if there is a connection between patient and provider. All new patient visits require a reason for visit - for a variety of reasons we prefer that to be a problem focused visit rather than a wellness check - but there must be a reason! If for some reason there isn't a connection between patient and provider after that first visit, we have other providers accepting new patients and there will be no bad feelings if you opt to switch providers. If after that visit you prefer not to continue care in our office we will be happy to pass along your records to your new provider.

So… what happens next? Here are the nuts & bolts of our process:

1) If you need any medications refilled, or are in the middle of a complex treatment contact your current primary care provider to coordinate. Once your records are sent to us, they may not provide you with any refills - but we cannot guarantee your acceptance into our practice and continuation of treatment plans until your records have been received, reviewed, and approved by your designated primary care in our office.

2) Complete our new patient registration packet and submit it to us by mail, fax or in person.

3) We will create a chart for you in our electronic system and submit your medical records requests to your previous providers.

4) The record request process can take up to a month for some facilities to send records, so we ask patients to check back periodically to see if records have been received and reviewed so a new patient appointment can be scheduled. If you need to be seen acutely before records have been received, you may be referred to an urgent care center in the interim.

5) Once records have been received, they are forwarded along to your designated Primary Care Provider for review and acceptance. If there are any concerns based on your history, you will be contacted. If not, you will be marked as an accepted patient in our system who is able to schedule appointments.

RICHMOND
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30 West Main Street
Richmond, VT 05477

Welcome to Richmond Family Medicine!
We are very excited you have joined our practice and we sincerely hope you are happy with the care you receive. As a new patient to our practice, you may have some questions about how we operate, how to contact us, and what to expect of this new relationship with us. The information below will hopefully help to address some of those questions, but please feel free to contact us if you need more information at any point.

What exactly is Family Medicine?
Family Medicine is a specialty which provides ongoing comprehensive care for individuals and families. The scope of Family Medicine is broad, as it incorporates a variety of specialties into the care for patients of all ages, genders, and medical conditions. Our approach toward medicine is to evaluate the whole person, and work with our patients to improve health and prevent disease. We follow evidence based medicine practices in caring for our patients. As your primary care resource, we also help coordinate care with other specialists or facilities.

How to reach us:

By phone:	(802) 434.4123
On the web:	www.richmondfamilymedicine.org (and we're on Facebook!)

Our Hours:

Monday - Friday:	8:00-5:00
Saturday:	9:00-12:00 (*For urgent concerns only)
After hours:	An on call clinician is always available for urgent concerns through our paging service. To reach a clinician off hours, dial our main line and press "1" to have a clinician paged.

What you can expect from us:
In our practice, we offer a broad range of services & treatments for patients of all ages, including:

- Immunizations
- Women's health care
- A wide variety of in house lab tests
- Psychiatric care
- Annual Physicals
- Well Child Check-ups
- Urgent care (injuries, cuts, stitches)
- Medicine management
- Medicare Wellness Exams
- Chronic condition management
- Common illnesses (fever, flu, colds)
- Nutrition counseling

If you are ever unsure if or when you should come in to see us, please call. Our nursing staff can assist in your decision making process. Our clinical staff can process refills for some prescriptions over the phone. Both of these options are available through our phone system.

How you can help us in your care:

- Before your visit, write down a list of concerns and questions so we can be sure nothing important is missed
- Provide us with a list of all medications (including over the counter medications)
- Call us before you go to the Emergency Room or hospital, or at least let us know as soon as possible that you've gone
- Arrive early for appointments, or provide 24 hours' notice if you are unable to keep an appointment
- Understand your insurance coverage and notify us of any significant changes to your records
- Let us know if you are seeing any specialists/providers, and sign a release so we may coordinate care
- Be an active participant in your healthcare and take care of your mind and body!

We're so happy you chose to join our practice, and we look forward to a long relationship with you and your family. Please let us know how we can serve you best – we appreciate and welcome your feedback.

Sincerely,
Dr. Daniel Goodyear ***Dr. Hannah Rabin*** ***Dr. Gil Theriault*** ***Courtney Ledger, APRN***
Kristy Garbarino, APRN ***Rachel Putnam, APRN***

PAYMENT IS YOUR RESPONSIBILITY *(copy for your records)*

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 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.
- If you have a deductible based plan, we may also collect a portion of today's fees at your 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 Fletcher Allen for testing. THESE SERVICES ARE BILLED DIRECTLY BY FLETCHER ALLEN

I HAVE READ THE ABOVE PARAGRAPH AND UNDERSTAND MY RESPONSIBILITY.

SIGNATURE: _____ *Signed Electronically* _____ DATE: _____

PATIENT CONSENT FORM *(copy for your records)*

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 at any point.
- This 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 your insurance carrier
    - Sending bloodwork or other samples to Fletcher Allen or other testing facilities
    - Immunization records to the state and to schools
- 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.
- 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 below, you are also giving this office permission to electronically retrieve your prescription record from your pharmacy.
- With your signature, you are authorizing our clinical staff to access your medical information from Fletcher Allen's electronic health record AND the statewide electronic health record (VITL)

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.

PRINTED NAME:_____RELATIONSHIP TO PATIENT:_____

SIGNATURE: _____ *Signed Electronically* _____ DATE: _____

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): _____

Optional: *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 2 years		
❑	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

RICHMOND
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30 West Main Street
Richmond, VT 05477

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)			
Gallblader 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									
Alzheimers									
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

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):_____