SHAFTSBURY MEDICAL ASSOCIATES, INC

PO Box 379 677 Vt. Rte. 7A Shaftsbury, Vt 05262
Phone: 802-442-8531 Fax: 802-442-1503

BILLING AND REGISTRATION FORM

(Please Print So We Can Read) Thank You!

PATIENT'S NAME: ______________________________ ________________________________
(LAST) (Middle Initial) (FIRST)

DATE OF BIRTH: __________________________ SOCIAL SECURITY #: ________-_______-___________

GENDER: MALE FEMALE MARITAL STATUS: S M D W CHILD

RACE: ____________________________ETHNICITY: _________________

MAILING ADDRESS: ____

CITY: ________________________________ STATE: ________________ ZIP: ___________________

HOME PHONE #:_________________________________ CELL PHONE #:______________________________________

EMAIL ADDRESS: ____

WHAT DRUG STORE DO YOU USE: __________________________?

EMERGENCY CONTACT NAME AND PHONE #:____

RELATIONSHIP TO THAT PERSON: _________________________________

NAME OF EMPLOYER: ___________________________________WORK PH #:_________________________________

JOB POSITION: ____

NAME OF GUARANTOR :(THE PERSON WHO IS RESPOSIBLE FOR THIS ACCOUNT):____

DATE OF BIRTH OF THAT PERSON: __________________________RELATIONSHIP: _________________________________

ADDRESS: ____PHONE #:____________________________________

PRIMARY INSURANCE: ________________________________

CERTIFICATE OR ID # __________________________________

GROUP #: ________________________________

SUBSCRIBER NAME: _______________________________D.O.B:_______________________

SECONDARY INSURANCE: ____________________________

CERTIFICATE OR ID #: __________________________________

GROUP #: ____

SUBSCRIBER NAME: _________________________________ D.O.B: ____

PATIENT HEALTH HISTORY FORM

DATE: ___________________

NAME: ____D.O. B_____________________

SS# ______-____-_______ PRIMARY CARE DR. SELECTED BY YOU: _________________________________
(DR. KING, DR. HAND, DR. NIEMI, PENNY BRUSO FNP, TOM BUCK, PA)

PAST MEDICAL HISTORY – Please put a check mark if you have had any of the following:

_ Asthma	_ Kidney Disease	_ High Cholesterol
_ Emphysema	_ Arthritis	_TB
_ High Blood Pressure	_ Aids	Bleeding Disorder
_ Congestive Heart Failure	_ Cancer	_ Depression
_ Angina (Heart Attack)	_ Diabetes	_ Hepatitis/ Liver Problems
_ Alcoholism	_ Thyroid Disease	_ Stroke
_ Seizure Disorder	_ Migraines	

PLEASE DESCRIBE ANY OTHER MEDICAL CONDITIONS NOT LISTED ABOVE:
____
____
____

MEDICATIONS: (Please list all medications that you currently take)

NAME	DOSE	NAME	DOSE
________________________	_________	_________________________	__________
________________________	_________	_________________________	__________
________________________	_________	_________________________	__________
________________________	_________	_________________________	__________

LIST ANY ALLERGIES TO MEDICATIONS:
____
____

FAMILY HISTORY- Has a member of your immediate family ever had.... (Mother, father, sister, brother) ....

_ Hypertension	_ Alcoholism	_ Diabetes	_ Anesthesia reaction
_ Heart Attack	_ Cancer	_ Stroke	_ Arthritis

PAST SURGICAL HISTORY:

Procedure_______________________________Date_______________Complications___________________________
Procedure_______________________________Date_______________Complications___________________________
Procedure_______________________________Date_______________Complications___________________________
Procedure_______________________________Date_______________Complications___________________________
HAVE YOU EVER HAD ANESTHESIA? _____YES _____NO ADVERSE REACTION? ____YES _____NO

SOCIAL HISTORY:
Smoke Currently? ____YES ____NO _____Packs per day for ______years
Quit Smoking? _________this year _______>1 year _______> 5 years ______> 10 years
Previously smoked: _________ packs per day for _________years.
Drink Alcohol: ________daily _____1-2 drinks per week ____1-2 drinks per month ____ per year
Your Height _________ Your Weight_________
Exercise: __________________daily__________3-4 times/week _________1-2 times a week ________rarely
Occupation: ____
Marital Status: _______married ______single ________divorced ________widowed
Children: _____NO ______YES How many? __________

Reviewed by: ____MD/PA-C Date: ________________

Shaftsbury Medical Associates

ACKNOWLEDGMENT OF PRIVACY PRACTICES/ COMMUNICATION AUTHORIZATION

NAME: _________________________________ DOB: __________________

I have received the Notice of Privacy Practice for Protected Health Information of Shaftsbury Medical and had all of my questions answered regarding its contents.

I consent to the use of or disclosure of my protected health information by Shaftsbury Medical Assoc. for the purpose of providing treatment, obtaining payment or conducting health care operations as explained in the Notice of Privacy Practice. I may revoke this consent in writing except if actions rely on this consent.

For Medicare beneficiaries If you choose to let Medicare share your health care information with OneCare Vermont, it may also be shared with other ACOs in which your other doctors or healthcare providers participate. If you don't want your health care information shared, you can ask Medicare not share it.

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- ☐ **I AUTHORIZE SHAFTSBURY MEDICAL TO LEAVE MESSAGES ON MY PHONE'S ANSWERING MACHINE**
- ☐ **I AUTHORIZE SHAFTSBURY MEDICAL TO SPEAK TO THE FOLLOWING PEOPLE (PLEASE LIST ANYONE THAT YOU WISH US TO BE ABLE TO SPEAK FREELY WITH AND THE RELATIONSHIP TO YOU):**

  ____

  ____

  ____

- ☐ **I do NOT Authorize Shaftsbury Medical to speak to ANYONE other than DR to DR without contacting me first.**

SIGNATURE: **____DATE: ____________________________________**

Relationship to Patient (if not self) ____________________

PAYMENT POLICY

If you have insurance that requires a CO-PAYMENT, the amount is due at the time of service or your appointment may be rescheduled.

We accept personal checks, Visa, Master card, Discover and cash.

I hereby authorize Shaftsbury Medical to recover from my insurance, payment of any services Shaftsbury Medical provides to me. I understand that I am financially responsible for all charges not covered by insurance. I hereby authorize Shaftsbury medical to release all information necessary to secure such payments. A photocopy of this statement is considered as valid as the original

Signature: **____Date: ______________________________________**

Relationship to Patient (if not self) ____________________

Shaftsbury Medical Associates Inc.'s Financial Policy

PAYMENT IS EXPECTED WHEN YOU COME IN FOR AN APPOINTMENT

- Co-payments, where applicable are due upon check-in.
- Any deductible is due as soon as the amount can be determined.
- You are responsible for understanding what your insurance plan will cover or not cover.
- As a courtesy, we will bill non-participating insurance companies.

NOTIFY US OF ANY CHANGES IN YOUR ADDRESS AND/OR INSURANCE

- If your insurance changed, bring your new insurance card with you.
- Please contact your insurance company with any insurance questions.

STATEMENTS ARE GENERATED FOR OUTSTANDING BALANCES

- If you are responsible for more than one patient account, we may offset an overpayment in one account to another account.
- We will assess a **service fee** for any checks returned unpaid.
- If payment is not received within **30 days** of the statement date, your account will be considered delinquent.

WE USE COLLECTION AGENCIES FOR DELINQUENT ACCOUNTS

- If your account is delinquent, we may list your default with credit reporting agencies.
- If you have a balance due, payment may be required before appointments are scheduled.
- If we incur any collection costs, these may be added to the balance you owe.

NOTIFY US TO CANCEL AN APPOINTMENT

- If you need to cancel an appointment, notify us **at least 24 hours before** the appointment.
- If you miss an appointment or are late in cancelling it, we may assess a **$50 fee**.
- If you frequently miss or cancel appointments, you may be discharged from our practice.

WE DO CONTACT PATIENTS FOR REMINDERS AND ACCOUNT FOLLOW-UP

- You authorize us or our agents to contact you using any contact information you provide to us including e-mail addresses and wireless telephone numbers (please note some wireless phone plans assess usage fees).

I have read the above Financial Policy of Shaftsbury Medical Associates Inc. and agree to its terms. I am responsible for any balances due on my account and any other patient(s) listed below.

If patient is not yourself, please name: ____________________________
____

____________________________ ____________________________

____________________________ ____________________________

Signature of patient, parent or authorized representative:
____

Date: ___/___/______

NOTICE OF PRIVACY PRACTICE FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ THIS CAREFULLY.

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health- care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for these services.

YOU'RE HEALTH INFORMATION RIGHTS:
The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- **Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to the office. We are not required to grant the request but we will comply with any request granted.**
- **Request that you be allowed to inspect and copy your health record and billing record-- you may exercise this right by delivering the request in writing to the office.**
- **Appeal a denial of access to your protected health information except in certain circumstances.**
- **Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to the office.**
- **File any statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all full disclosures of your protected health information.**
- **Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to the office. An accounting will not include internal uses of information for treatment, payment or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course providing care.**
- **Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to the office.**
- **Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to the office.**

If you wish to exercise any of the above rights, please contact Michelle Metcalfe Privacy officer, in person or in writing, during normal business hours. She will provide you with assistance on the steps to take to exercise these rights.

RESPONSIBILITIES OF SHAFTSBURY MEDICAL ASSOCIATES
The practice is required to:

- **Maintain the privacy of your health information as required by law**
- **Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you.**
- **Abide by the terms of this notice.**
- **Accommodate your reasonable requests regarding methods to communicate health information with you.**

Shaftsbury Medical Associates reserves the right to amend, change, or eliminate provisions in its privacy practices and access practices and to enact new provisions regarding the protected health information maintained here. If the information practices change, this notice will be amended. You are entitled to receive a revised copy of this notice by calling and requesting a copy of your "Notice" or by picking up a copy at our office.

TO REQUEST INFORMATION OR FILE A COMPLAINT:
If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Michelle Metcalfe Privacy Officer or Sandra Hewson Loveland Office Manager. Additionally if you believe your privacy rights have been violated, you may file a written complaint at the office by delivering the written complaint to either Michelle or Sandy. You may also file a complaint by mailing it to or e-mailing it to the Secretary of Health and Human Services whose street address and email address is 200 Independence Ave. SW, Washington, DC 20201 and HHS.mail@HHS.gov**. We cannot, and will not require you to waive the right to file a complaint with the secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice. We cannot, and will not retaliate against you for filing a complaint with the Secretary.**

OTHER DISCLOSURES AND USES NOTIFICATION:
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

COMMUNICATION WITH FAMILY:
Using our best judgment and professionalism, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your case or in payment for such care if you do not object or in an emergency.

FOOD AND DRUG ADMINISTRATION (FDA):
We may disclose to FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs or replacements.

WORKERS COMPENSATION:
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

PUBLIC HEALTH:
As required by law, we may disclose your protected health information to public health or legal authorities charge with preventing or controlling disease, injury or disability.

ABUSE AND NEGLECT: We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

CORRECTIONAL INSTITUTION:

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and health and safety of other individuals.

LAW ENFORCEMENT:

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, during cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

HEALTH OVERSIGHT:

Federal law allows us to release your protected health information to appropriate health oversight agencies over health oversight activities.

JUDICIAL/ADMINISTRATIVE PROCEEDINGS:

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court date.

OTHER USES:

Other uses and disclosures besides those identified in this notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

RESEARCH:

We may disclose information to researchers when institutional review board has reviewed a research proposal, approved the research and establish protocols to insure the privacy of your protected health information.

This medical practice participates in the Vermont Blueprint for Health, a statewide health care delivery reform initiative whose purpose is to improve the health of Vermonters. The Vermont Blueprint for Health provides additional resources to this medical practice to assist them with better support and coordination of care for its patients. These additional resources may include a nurse case manager, dietitian, behavioral health therapist and social worker, and are referred to as the Community Health Team (CHT). Members of the CHT are not employed by this medical practice.

The CHT will have access to protected health information and will share that information with each other and with physicians and healthcare providers involved in your care for the purposes of treatment, payment, and health care administration/operations. This protected health information may include your complete medical record, which may contain information regarding mental health, alcohol or drug abuse treatment, and/or HIV-related illness. This exchange of the protected health information will enable the physician or health care provider and the CHT to better understand your health care needs and to plan and provide services to meet those needs.

The CHT will document its activities in your medical record and in the Vermont Blueprint for Health information system. This medical practice may use the Vermont Blueprint for Health information to support your health care needs. The Vermont Blueprint for Health will use information from the Vermont Blueprint for Health information system for the evaluation of the Vermont Blueprint for Health initiative; the information does not identify individual patients. No information will be released to the general public.

Shaftsbury Medical Associates is participating in a Medicare Shared Savings Program Accountable Care Organization

Accountable Care Organizations (ACOs): Providing Better, Coordinated Care for You

[Shaftsbury Medical Associates] is participating in OneCare Vermont, a Medicare Shared Savings Program ACO. An ACO is a group of doctors, hospitals, and/or other health care providers working together with Medicare to give you better, more coordinated service and health care. Think of an ACO as a team made up of your doctors and other health care providers. We are working together to share important information and resources about your individual needs and preferences.

Doctors and hospitals in an ACO communicate with you and with each other to make sure that you get the care you need when you're sick, and the support you need to stay healthy.

You Can Still Choose Any Doctor or Hospital

Your Medicare benefits aren't changing. ACOs are not a Medicare Advantage plan, an HMO plan, or an insurance plan of any kind. You still have the right to use any doctor or hospital that accepts Medicare, at any time. Your doctor may recommend that you see particular doctors or health care providers, but it's always your choice about what doctors and providers you use or hospitals you visit.

Having Your Health Information Gives Us a More Complete Picture of Your Health

To help OneCare Vermont give you better, coordinated care, Medicare will share information with us about your care. The information will include things like dates and times you visited a doctor or hospital, your medical conditions, and a list of past and current prescriptions.

This information from other healthcare providers will give [Shaftsbury Medical Associates] and other healthcare providers in the ACO a more complete and up-to-date picture of your health.

If you choose to let Medicare share your health care information with OneCare Vermont, it may also be shared with other ACOs in which you're other doctors or healthcare providers participate. If you don't want your health care information shared, you can ask Medicare not share it.

Your Privacy is Very Important to Us

Just like Medicare, ACOs must put important safeguards in place to make sure all your health care information is safe. ACOs respect your choice on the use of your health care information for care coordination and quality improvement.

Yes, share my information: If you want Medicare to share information about care you have received with us and with other ACOs in which any of your doctors or other healthcare providers participate, then there's nothing more you need to do.

No, please don't share my information: If you don't want Medicare to share information with OneCare Vermont or with any other ACOs for care coordination and quality improvement purposes, you must do the following:Call 1-800-MEDICARE (1-800-633-4227). Tell the representative you are calling about ACOs and that you do not want Medicare to share your health care information with ACOs. TTY users should call 1-877-486-2048.

- **If you change your mind in the future, call 1-800-MEDICARE and tell the representative what you have decided. We can't communicate with Medicare on your behalf.**

Even if you decline to share your health care information, Medicare will still use your information for some purposes, including certain financial calculations and determining the quality of care given by your healthcare providers participating in ACOs. Also, Medicare may share some of your health care information with ACOs when measuring the quality of care given by healthcare providers participating in ACOs.

Questions?

If you have questions or concerns, call us at 1-877-644-7176 or we can discuss them next time you're in our office. You also can call 1-800-MEDICARE and tell the representative you're calling to learn more about ACOs, or visit Medicare.gov/acos.html.

END OF DOCUMENT

SHAFTSBURY MEDICAL ASSOCIATES, INC.
677 VT RTE 7A
PO BOX 379
SHAFTSBURY, VERMONT 05262
PH # (802)442-8531 FAX # (802)442-1503

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

NAME ON MEDICAL RECORDS: ____

DATE OF BIRTH: ____________________________

SOCIAL SECURITY NUMBER: ___________-___________-__________

I HEARBY AUTHORIZE AND REQUEST MY RECORDS BE
SENT TO_______RECIEVED FROM________
(CHECK ONE)

MEDICAL PROFESSIONAL, FACILITY OR PERSONS NAME:

NAME: ____

ADDRESS: ____

CITY: ___________________________ **STATE:** ____________________ **ZIP:** ______________

PHONE #: ________-_______-__________ **FAX #:** ________-________-________

CHECK ONE:

- ☐ **The COMPLETE medical records from this practice. (Including those records received from other medical practices.)**
- ☐ **Medical records concerning my illness/injury and /or treatment during the period From __________to __________, including laboratory reports, x ray, consultation Reports, and other tests reports.**
- ☐ **Other:** ____

The information will be used / disclosed for the following purpose(s):

- ☐ **Requested by the patient and for the patient (not necessary to disclose purpose).**
- ☐ **Transfer of care**
- ☐ **Insurance claim**
- ☐ **Other: (Describe)** ____

- ☐ **I understand that this authorization is voluntary.**
- ☐ **I understand that a fee for cost of processing this request may be charged.**
- ☐ **I understand that I may revoke this authorization at any time by notifying SMAI, in writing, except to the extent that: 1. Action has already been taken in reliance on this authorization; or 2. If this authorization is obtained as a condition of obtaining coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.**

I understand that my records may include drug/alcohol, HIV and/or mental health records and any other material regarding medical consultations and treatment I have received. By signing below, I authorize release of my records as checked above which may include drug/alcohol, HIV and/or mental health records, unless indicated below. (This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless the further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CRF Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.)

____ **Date:** ________________________
(Patient, Parent or Guardian Signature)

☐ **DO NOT RELEASE DRUG/ALCOHOL, HIV, AND/OR MENTAL HEALTH RECORDS.**

____ **Date:** ________________________
(Patient, Parent or Guardian Signature)

THIS RELEASE EXPIRES ON: ________________________ **STAFF USE:** ___________ **INFORMATION REQUESTED SENT**