Welcome to Shaftsbury Medical Associates, Inc.

Our practice provides complete primary care for adults and children, to our area, and surrounding towns. We are pleased to announce that we are a NCQA Patient Centered Medical Home Recognized Practice providing nurse case management, mental health, nutritional and transition of care services free of charge to our patients. We are dedicated in coordinating your care with other providers in the area and local hospitals such as SVMC, Dartmouth, Berkshire Medical, Albany Medical and Rutland Regional Medical Ctr.

We have a Physician, a Nurse Practicioner and Physician Associate on Staff. Our nurses and support staff are very dedeicated to providing the best medical care for you and your family.

We do have 24 hours 7 day a week coverage for all after hours. To reach a provider, call 802-442-8531, and your call will be forwarded to the on-call provider's cell phone. **In case of an emergency call 9-1-1.**

Routine Office Hours are Monday- Friday 8am -5pm
To make an appointment call 802-442-8531. The office is closed everyday for lunch between 12-1 pm. We offer same day appointments for routine and urgent care. Services Offered: Routine Medical Care, Follow-up Care, Pediatrics, Women's Health, Geriatrics, Health Promotions, Minor surgery and Immunizations.

Our practice accepts most insurances. Call our office with any questions regarding your insurance plan. We will do our best to assist you.

We encourage you to use our website shaftsburymedical.com. Contact our office to receive your temporary user name and password to be able to login to our portal. Once registered you can view your medical records and message our office securely with non-emergent requests. Messages sent in the evening will be received as soon as the office is open the next business day.

We are located at 677 VT Rte 7A Shaftsbury VT 05262. Mailing address PO Box 379 Shaftsbury VT 05262. Telephone # 802-442-8531. Fax: #802-442-1503.

NEW PATIENT REGISTRATION PACKET

* Please complete and return this packet to SMAI *

Today's Date			Primary Care Provider (PCP)	
Last Name	First	MI	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Is this your legal name? If not, what is? ☐ yes ☐ no _____

Mailing Address	Physical Address (if different)	City	State	Zip

Preferred Phone # (___) ___-____	Cell Phone # (___) ___-____	_____ Phone # (___) ___-____	Marital Status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Sep. ☐ Civil Union

Date of Birth __/__/____	Social Security # ___-___-____	Gender ☐ M ☐ F ☐ T	Occupation	Employer

EMERGENCY CONTACT INFORMATION

Name	Relationship to Patient	Phone Number

PRIMARY INSURANCE INFORMATION

☐ I currently have medical insurance ☐ I currently do not have medical insurance ☐ I would like to apply for the Sliding Fee Scale

Medical Insurance Name	Policy Number	Group Number
Policy Holder's Name	**Policy Holder's Date of Birth** __/__/____	**Policy Holder's Employer**

SECONDARY INSURANCE INFORMATION

☐ I currently have secondary insurance ☐ I currently do not have secondary insurance (disregard this section)

Secondary Insurance Name	Policy Number	Group Number
Policy Holder's Name	**Policy Holder's Date of Birth** __/__/____	**Policy Holder's Employer**

ADDITIONAL INFORMATION

Race ☐ African-American/Black ☐ Multi-Racial ☐ Asian-American ☐ Caucasian/White ☐ Native American ☐ Other _____	Primary Language if not English _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Status (check all that apply) ☐ Veteran ☐ Seasonal ☐ Homeless ☐ Migrant	Do you need interpreter services? ☐ yes ☐ no

- **What pharmacy do you use?**_____

EMAIL ADDRESS:

TO THE BEST OF MY KNOWLEDGE, THE PRECEDING ANSWERS ARE TRUE AND CORRECT: _____

Signature of Patient or Parent/Legal Guardian

Packet updated 7/19/2017

Please complete all asterisk (*) sections of this questionnaire. The remaining sections are optional but would help your healthcare team to know you better. All information provided is kept confidential.

* PERSONAL MEDICAL HISTORY AND HABITS *

*** Conditions I have** (check all that apply)

☐ Asthma ☐ Cancer ☐ Depression ☐ Diabetes ☐ Emphysema/COPD ☐ Heart Disease ☐ High Blood Pressure
☐ High Cholesterol ☐ Sleep Apnea ☐ Stroke ☐ Thyroid Disorder

*** Medications** (include all medications, including over the counter medications, vitamins/minerals/other supplements, and herbal products) ☐ **No Current Medications**

Name of Medicine	Dose	Times per day	What for?	Side effects, if any

*** Allergies and adverse food/drug reactions** ☐ **No Known Allergies**

Food, Drug or Substance	Type of reaction

*** Immunizations** (state the month and year of the most recent shot or when series was completed)

Tetanus shot _____
Hepatitis B Series _____
Shingles Vaccine _____
HPV Vaccine Series _____
Flu Shot _____
Pneumonia Shot _____

*** Do you smoke?**

☐ yes ☐ no ☐ in the past

Age you started: _____

Average packs/day during your smoking: _____

If you have quit, age when you did: _____

*** Other tobacco use:**

☐ Chewing/Oral
☐ Cigars
☐ Pipe

Age you started: _____

If you have quit, age when you did: _____

*** Do you drink alcohol?**

☐ yes ☐ no ☐ in the past

How many drinks per - day? _____ or week? _____ or month? _____ or year? _____

What is the maximum number of drinks you have had in one session in the last year?

*** Caffeine Intake:**

How many of each per day?

Coffee _____
Tea _____
Soda _____

*** Exercise:** Aerobic - Type(s) _____ Duration per session _____ Times per week _____

Weightlifting/ resistance training - times per week _____ Combined - Type(s) (boot camps, etc.) _____ Times per week _____

*** In the last two weeks**

- I have had little interest or pleasure in doing things ☐ not at all ☐ on several days ☐ more than half the days ☐ nearly every day
- I have been feeling down, depressed, or hopeless ☐ not at all ☐ on several days ☐ more than half the days ☐ nearly every day

Name: _____
DOB: __/__/____

- **Do you have a Gun in your home? ☐yes ☐no**

HOUSEHOLD INFORMATION

Name of other members in your household (if applicable)	Age	Relationship

EDUCATION

High School Grade Level Completed:	College Number of Years Completed:	
☐ 9 ☐ 10 ☐ 11 ☐ 12	☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ Masters Subject: _____ ☐ Doctorate Subject: _____ ☐ Other _____

EMPLOYMENT HISTORY

Occupation	Employer	How long	Workforce Issues/Hazards/Concerns
Current _____	_____	_____	_____
Previous _____	_____	_____	_____
Previous _____	_____	_____	_____

SEXUAL ORIENTATION AND GENDER IDENTITY

Do you think of yourself as:

☐ Lesbian/Gay ☐ Straight (not lesbian or gay)
☐ Bisexual ☐ Other _____
☐ Don't know ☐ Choose not to disclose

What is your current gender identity?

☐ Male ☐ Female ☐ MTF Transgender ☐ FTM Transgender
☐ Other _____ ☐ Don't know ☐ Choose not to disclose

What sex were you assigned at birth?	What is your preferred name?	What are your preferred pronouns?
☐ Male ☐ Female ☐ Intersex ☐ Choose not to disclose	_____	☐ She/her ☐ He/his ☐ They/their ☐ Other _____

Name: _____

DOB: __/__/____

PERMISSION TO RELEASE PATIENT INFORMATION

If you have a spouse, friend or relative that may call on your behalf to obtain appointment dates and times, test results, etc., we **will not** give that information out unless their name is provided for our records*. Please initial the option you choose.

- Option 1 _____ I hereby give permission to Shaftsbury Medical Associates Inc. (SMAI) to release the selected information about me to those listed below should they call or come in to inquire. Please check what you will allow to be released.

  ☐ Medical Test Results ☐ Medications ☐ Appointment Confirmation ☐ Other _____

  * Patients requesting information in regards to drug and alcohol counseling/treatment need to complete a separate authorization. No drug and alcohol information will be given without this permission.

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

- Option 2 _____ I do not consent to release information about me to others, except as I have consented in other authorizations or consents provided to me by Shaftsbury Medical Associates, Inc., or as required by law.

USE OF EMAIL

I understand that SMAI and I may exchange information via e-mail/patient portal per my request.

☐ I do wish to have SMAI contact me via e-mail ☐ I do not wish to have SMAI contact me via e-mail.

E-mail address: _____

ABOUT OUR NOTICE OF PRIVACY PRACTICES

SMAI is committed to protecting your personal health information in compliance with the law. In summary, SMAI'S Notice of Privacy Practices includes:

- Our obligations under the law with respect to your personal health information
- How we may use and disclose the health information that we keep about you
- Your right relating to your personal health information
- Our right to change our Notice of Privacy Practices
- How to file a complaint if you believe your privacy rights have been violated
- The conditions that apply to uses and disclosures not described in the document
- The person to contact for further information about our Privacy Practices

We are required by law to give you a copy of this notice and obtain your written acknowledgement that you have received a copy of the Notice.

I HAVE COMPLETED THE PERMISSION TO RELEASE PATIENT INFORMATION;
I HAVE COMPLETED AND UNDERSTAND THE USE OF E-MAIL;
AND I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES.

_____	_____	_____
Name of Patient (please print)	Date of Birth	Name of Personal Representative (please print)
_____	_____	_____
Signature of Patient or Parent/Legal Guardian	Date	Description of Legal Authority to Act on Behalf of the Patient

CONSENT FOR TREATMENT AND CONSENT FOR THE RELEASE OF PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATION

I. Consent for Treatment

I hereby give my consent for treatment for myself, or the named patient for whom I am the parent or legal guardian, to Shaftsbury Medical Associates Inc. (SMAI). Treatment may include health screenings, diagnosis, medical treatment, minor procedures, social services and mental health; drug and alcohol screening, assessment, diagnosis, and treatment.

II. Consent to Release Personal Health Information for Treatment, Payment, and Healthcare Operations

I hereby give my consent for the use within SMAI and the disclosure to persons or organizations outside of SMAI my, or of the named patient for whom I am the parent or legal guardian, medical, mental health, drug and alcohol, health records and information - such health records and information are referred to in this Consent as "Personal Health Information, (PHI)" - by SMAI for the following purposes:

A. Use of PHI by or for SMAI for Treatment and for Healthcare Operations:

- Providing treatment by SMAI staff;
- Conducting healthcare operations of SMAI including, for example, financial or quality assurance audits and training.

B. Disclosure of PHI to Persons outside SMAI for Treatment Purposes and for Payment:

- Providing PHI to other health providers or agencies who are or will be involved in my care (except for treatment information concerning drug or alcohol abuse, for which a separate consent is required);
- Obtaining payment for healthcare bills, including sending such PHI as is needed to secure payment for SMAI services to the insurance company, worker's compensation company or agency that pays for my health services, as identified in my SMAI registration form or other updated insurance information on file with SMAI.

III. Other Matters

I understand that I have the right to revoke this Consent at any time. Revoking this Consent will not affect any actions taken by SMAI before consent was revoked. If not revoked, this consent will terminate on the following date, event, or condition: _____ . If none is indicated, this consent will terminate two years after the last date of services to me.

I understand that I may request restrictions on use or disclosure of my PHI for the purposes described in this Consent and that SMAI may or may not agree to the requested restrictions. I also understand that except for those restrictions on use or disclosure of PHI to which it agrees, SMAI will not be able to provide services to me (or the named patient) without this signed Consent.

I understand and acknowledge that I am financially responsible for any unpaid balances incurred as a result of my care at SMAI.

I HAVE READ ALL OF THE INFORMATION ABOVE AND I UNDERSTAND AND CONSENT TO ITS CONTENT.

_____	_____	_____
Name of Patient (please print)	Date of Birth	Name of Personal Representative (please print)
_____	_____	
Signature of Patient or Parent/Legal Guardian	Date	

Vermont Health Information Exchange Consent Form

Patient name (Last, First, MI) | Patient birthdate

Patient address

SHAFTSBURY MEDICAL ASSOCIATION

Name of Health Care Organization receiving this form

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 to 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.

Providers may see your medical records without your consent if you need emergency care.

By giving my consent and signing this form, I agree to the following:

- I have been offered a brochure with more information about the exchange. I can ask Vermont Information Technology Leaders, Inc. (VITL), the State of Vermont Blueprint for Health, or my health care provider about how my medical records are kept private.
- I can choose to give or not to 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.
- If I sign a revocation form all my providers must stop seeing and using my medical records from other providers on the exchange. I can get that form from my health care providers or from VITL. That form will not apply to information from the exchange that my providers have already used and put in their medical records.

Please check only one of the following:

◯ I give my consent (Opt-in) for all providers who care for me now and in the future:

a. to use a health information exchange to see and use my medical records from other providers. This may include mental health and substance abuse treatment records. They can use the medical records to get paid for my care. They can use the medical records for health care operations. My providers may only use my medical records as allowed under HIPAA and Vermont laws.

b. to use the exchange to see and use information about my prescriptions. These prescriptions may come from many different sources. This may include mental health care and substance abuse treatment providers. They may also come from pharmacies, insurance plans, and pharmacy benefit managers.

◯ I do not give my consent (Opt-out).

Signature of Patient (if patient is 12 years or older) | Date

Signature of Parent or Authorized Representative (If patient is under age 18 or patient is incapacitated) | Date

Name of Parent or Authorized Representative | Relationship to Patient

For more information about this form, contact VITL toll-free at **888-980-1243** or **www.vitl.net/privacy**

AUTHORIZATION TO REQUEST PROTECTED HEALTH INFORMATION

Facility/Provider Name: _____

Address: _____

Fax: _____ Phone: _____

I authorize the above facility to disclose the following protected health information to:

Shaftsbury Medical Associates Inc. Attn: Medical Records

| P.O. Box 379 | 677 Vt Rte 7A | Shaftsbury, VT | 05262 | p (802) 442-8531 | f (802) 442-1503

This authorization permits your facility to disclose the following individually identifiable health information about me:

- o All records in your possession, which may include records containing drug and/or alcohol use, HIV and mental health records.
- o "Medical Summary" of my healthcare from my electronic/ paper medical record. If this does not provide adequate information for my healthcare provider, I then authorize the release of all records in your possession, which may include records containing drug and/or alcohol use, HIV and mental health records.
- o Other specific information related to date, injury, disease,illness,etc:_____

This protected health information is being disclosed for the following purposes:

☐ Transfer of Care ☐ Continuity of Care ☐ Other _____

This authorization will be in effect until:

☐ No expiration ☐ One year from this date at which time this authorization to disclose this protected health information will expire ☐ Other _____

I understand that I have the right to revoke this authorization, in writing, at any time. My written revocation must be submitted to the Privacy Officer, Michelle Metcalfe, Shaftsbury Medical Assoc. Inc, P.O. Box 379, Shaftsbury, VT, 05262. I understand that a revocation is not effective to the extent that my healthcare provider has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim. My records may be releases by copies sent by mail, fax, or electronic copy by other transferable means.

I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. 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.)

_____ _____ _____

Name of Patient (please print) Date of Birth Name of Personal Representative (please print)

_____ _____

Signature of Patient or Parent/Legal Guardian Date