Village Health
5 Park St; Star Mill Suite 3A; Middlebury, VT 05753
Phone: 802-382-9491 Fax: 855-809-2105

Dear New Patient,

Thank you for choosing Village Health! We look forward to working with you to optimize your health and well-being. This is a new and exciting adventure in providing a different model of health care and we are so very pleased that you are partnering with us. This letter contains answers to the most commonly asked questions. We hope you will find this useful.

Our hours are Monday through Friday, 8:30 am to 4:30 pm. Our phone number is 802-382-9491. You will use this number any time you need to reach us, day or night. Outside of normal business hours your calls will be forwarded directly to Dr. Rouse or Ms. Wilkinson on their personal cell phones.

At Village Health we strongly believe that preventative medicine is the foundation of good health. Our philosophy supports prevention, early detection and early intervention. We believe that routine office visits are an important part of staying healthy and managing any chronic diseases you may have. In order to help you remember appointments, we have automated reminders that you can choose to receive in the form of a phone call, text message, or a message through your patient portal.

We understand that life happens and that there may be circumstances in which you will not be able to make a scheduled appointment. Please call and let us know as soon as possible, ideally 24 hours in advance of your appointment. If you do not appear for three appointments in a 12-month period, we may ask you to leave the practice. If you are struggling to find transportation to appointments, please call us, as we may be able to help arrange this.

Since we are dedicated to taking the best possible care of you, we are in the process of becoming certified as a Patient Centered Medical Home (PCMH). This recognizes that the patient is at the center of a care team consisting of providers, nurses, family, caregivers, and non-clinical professionals in the community. This process will allow us to provide you with access to Nutritionists, Behavioral Health Counselors, and Case Managers.

We are excited to offer you the convenience of a patient portal option. This will be available to you and can be used for non-emergent matters, such as refill requests and to review lab results.

Enclosed in this packet is a series of forms that we would like you to complete before your first visit with us. Please bring your insurance card, a photo ID, and a list of your medications with you to your first appointment.

Thanks again for entrusting us with your health.

Patient's Last Name:_____

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New Patient Information

Legal Name _____ Date of birth: _____

Birth Gender: _____ Gender Identity: _____

Address: _____ City: _____ Zip Code: _____

Home phone: _____ Work: _____ Mobile: _____

E-mail address: _____

Would you like to receive automated text reminding you of your upcoming appointment? **Yes** **No**

How would you like to be contacted: **Home** **Work** **Mobile** **Email**
(circle all that apply)

May we leave a medically related message? **Yes** **No**

Circle one: • Married • Single • Widowed • Divorced • Domestic Partner

Ethnicity: _____ Preferred Language: _____ Race: _____
Employer: _____ Occupation: _____

Household members:

_____
_____
_____
_____

Who would you like listed as your primary care physician:

Laura Wilkinson, FNP **Jessica Rouse, MD** **I am happy to see either as my primary**

Patient's Last Name:_____

Preferred Pharmacy Name: _____Town/City: _____

Preferred Laboratory Name: _____Town/City: _____

Preferred Imaging Facility Name: _____Town/City: _____

Primary Insurance Company:_____
SubscriberID#:_____
Group #: _____
Primary Subscriber Name: _____DOB_____
Address: _____City: _____ Zip Code: _____
Relationship to you: _____

Secondary Insurance Company:_____
SubscriberID#:_____
Group #: _____
Secondary Subscriber Name: _____DOB_____
Address: _____City: _____ Zip Code: _____
Relationship to you: _____

Emergency Contact: _____ Relationship to you: _____
Address: _____City: _____ Zip Code: _____
Home phone: _____ Work: _____ Mobile: _____

How did you hear about Village Health?

_____

Are you currently receiving healthcare by other practitioners/specialist? If so, who?

_____

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New Patient Past Medical History

Patient Name:	DOB:	
ALLERGIES		
CURRENT MEDICATIONS Name	Dose (mg, pill, etc.)	Times Per Day

OTHER PROVIDERS OR SPECIALISTS INVOLVED IN YOUR CARE		
Speciality	Name/Phone	Date of Last Visit
Mental Health		
Cardiology		
Neurology		
Pulmonary		
Other:		
Other:		
Other:		

PERSONAL SURGERY HISTORY		
Type	Date	Where?

Patient's Last Name:_____

HEALTH HISTORY

The general state of your health is: Excellent ___ Good ___ Average ___ Fair ___ Poor ___

Date of last colonoscopy: _____
Mammogram: _____
DXA/Bone Scan: _____
Date of your last Tetanus, Td, TdaP, or DTaP shot: _____

Do you require any hearing, vision or communication assistance, explain?

_____

Do you have an Advanced Care Directive?
____ If yes, where is it on file?
____If no, would you like more information on creating one?

PERSONAL HEALTH

Diet: Please describe a typical day's diet for you
Any avoided foods: _____
Daily water intake: _____
Breakfast _____
Lunch _____
Dinner _____
Snacks _____

Exercise: Briefly describe your exercise routine or activity level-include type, frequency, and time per session?

_____

Height: ____Current weight: ____Weight 1 year ago: ____Maximum weight: ___when? ____
Do you use alcohol, cigarettes, coffee, or recreational drugs? (sources/amount)

_____
_____
_____
_____

How is your sleep? Do you wake feeling rested? _____
What are your primary sources of stress? _____
What do you do in order to manage stress and take care of yourself? _____

PAST MEDICAL HISTORY Your health as a child? Good ___Fair ___Poor___

Patient's Last Name:_____

Childhood Illnesses (check (X) if you had it) ___ Chickenpox ___ Coxsackie ___ Diphtheria ___ Fifth's ___ Measles ___ German ___ Mono ___ Mumps ___ Polio ___ Rheumatic Fever ___ Rotavirus ___ Smallpox ___ Typhoid __ Tuberculosis ___ Whooping Cough

Do you have or have you ever had? (check (X) if you had it)

___ADD/ADHD	___AIDS/HIV	___Abuse/Domestic Violence
___Anemia	___Alcohol or Drug Abuse	___Anxiety Disorder
___Blood Diseases	___Birth Defects or Inherited Disease	___Bladder/Kidney probs.
___Breast Problem	___Cancer	
___COPD	___Coronary Artery Disease	___Depression
___Diabetes	___Diverticulitis	___Eating Disorder
___Eczema	___Endometriosis	___Fibromyalgia
___Gout	___Glaucoma	___Head Injury
___Heart Attack	___Heart Disease	___Hepatitis
___High Cholesterol	___High Blood Pressure	___Infertility
___Kidney Stones	___Liver Disease	___Lung Disease
___Mental Illness	___Muscle, Joint, or Bone Problem	___Obesity
___Osteoporosis	___Reflux/Gerd	___Seizures
___Skin Problems	___Stroke	___Thyroid Problem
___Tuberculosis	___Tick Bite(s)	___Varicosities
___Vision or Eye Problems	___Chronic ear infections	___ Other

FAMILY HEALTH HISTORY (be sure to include current age or age of death, major illness history, including diabetes, heart disease, osteoporosis, cancer, allergies, etc.)

Member Age/Living? Major illness or chronic conditions

Mother _____
Father _____
Siblings _____
Children _____
Mat. Grandmother _____
Mat. Grandfather _____
Pat. Grandmother _____
Pat. Grandfather _____

Do/did you smoke tobacco? (cigarette, pipe) ___Never __Former
___Current everyday ___Current some days

If you do/did smoke tobacco, how much/day? _____
How many years have you smoked? _____

Do you use smokeless tobacco products? No Yes

Do you use e-cigarettes/vape? No Yes

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Consent for the Release of Medical Information

Patient Name:	DOB:
Address:	
Phone Number:	

I hereby authorize Village Health to:

☐ Receive health information from:
(if you are a new patient needing records from your previous practice)

☐ Release health information to:
(if you are leaving Village Health)

Practice/Physician Name:	
Address:	
Phone Number:	Fax Number:

Reason for request:

☐ Transfer, moved out of area

☐ Transfer due to change in insurance

☐ Other:

The information to be released by Village Health shall be all pertinent records and will be released to the above-named practice by mail, electronic transfer, fax, or courier (when applicable).

★★The information released will include information related to AIDS, HIV infection, treatment for substance/alcohol abuse or dependency, and psychotherapy notes or information related to mental health or psychiatric care. If you wish to EXCLUDE this information from the records being released, please initial: ____

This information is being disclosed to the above person, organization or agent from records whose confidentiality may be protected by the Vermont Drug and Alcohol Abuse Control Act ,the Vermont Mental Health Procedures Act, and/or the Vermont Confidentiality of HIV Related Information Act. My signature below authorizes the release of information protected by these Vermont statutes, unless initialed above.

I understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization has been taken. However, I also understand that health information disclosed pursuant to this authorization may be subject to redisclosure because it is no longer protected by federal privacy laws. I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated. Village Health, Inc., its employees, officers, and clinical staff are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. Finally, I understand that I am entitled to obtain a copy of this authorization from Village Health upon request. This authorization shall expire 90 days from the date above unless otherwise noted.

Patient (18 years or older) or Parent/Guardian Signature:	
Date:	Relationship to Patient:

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2019-20 Membership Plan

We appreciate your understanding that our services are valuable. The membership fee provides two critical items that are all too scarce in medical care today - time and technology. Because we limit the number of patients we take care of, we can spend more time with you at your appointments. Investment in technology means that you can text a picture of a rash, or do a telemedicine visit over your phone or computer instead of coming into the office. We are committed to providing you access to medical advice that is convenient for you. Please feel free to consult with us to find the membership plan that is right for you and your family.

Choose your plan type:

Type	Monthly Cost	3 Month Cost	Annual Cost
☐ Individual Plan	$50	$150	$600

Individual plans cover comprehensive care at Village Health, including same day appointments for acute care issues, lengthened office visits when needed, and access to providers for critical questions via your preferred mode of communication when our office is closed.

☐ Individual Uninsured/ High Deductible Plan	$100	$300	$1200

In the "uninsured / high deductible plan", all of our provider services will be provided for the cost of the membership fee with no co-payment and your insurance company will not be billed for services occurring in our office. You will still be responsible for lab work and services outside of our offices.

☐ Household Plan	$75	$225	$900

Household Plan covered members will receive the same benefits as individuals with reduced cost for the whole family. Plan members are limited to immediate family members who reside with you full-time. Please list below which household members will be covered by this plan.

☐ Medicaid Plan (please ask for details)

Choose your payment installment:

Membership fees are due on the first of each month, in three-month installments or in a lump sum at the beginning of each fiscal year in accordance with your chosen payment plan.

☐ Monthly on the 1st ☐ Bill every 3 months ☐ Annual

Choose your payment method:

☐ Send me a bill

☐ Leave card on file for autopay at the above installment:

Card Number:
Cardholder Name:
Expiration Date:

Security Code _____

Membership fees will automatically renew at the following year's rate unless you notify us of a change in medical provider. Membership fees that have already been paid will be prorated in the event of patient transfer. Notification of changes to membership fees will be provided by Village Health at least 30 days in advance of billing.

I understand that by signing below I am committing to paying the membership fees for the plan at the agreed upon installment period unless cancelled by me.

Patient Name:	
Patient (18 years or older) or Parent/Guardian Signature:	
Date:	Relationship to Patient:
Guarantor's SSN:	Guarantor's DOB:

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Payment Policy

We are excited to work with you as medical partners! We appreciate your understanding that our services are valuable. Our payment policies are designed to help our practice provide you with the best possible care. By signing below, you state that you understand and agree to follow these policies.

1. **Membership Fees**: Membership fees are due on the first of each month, in quarterly installments or in a lump sum at the beginning of each year in accordance with your chosen payment plan. Membership fees will automatically renew at the following year's rate unless you notify us of a change in medical provider. Notification of changes to membership fees will be provided at least 30 days in advance of billing. Membership fees must be up-to-date at each appointment.
2. **Insurance:** We participate with most insurance plans. We ask you to bring your insurance card with you to every appointment. If you are uninsured or have experienced a lapse in coverage, please let us know so that we can work with you to establish a payment plan or re-establish insurance coverage for your visit.
3. **Co-Payments**: It is the patient's responsibility to pay the co-payment at the time of each visit.
4. **Non-Covered Services:** Some services provided by Village Health may not be covered by your insurance company. You will be responsible for the payment of these services.
5. **Coverage Changes**: If your insurance coverage changes, please let us know before your next appointment so that we can help ensure appropriate coverage for your medical care.
6. **Non-payment:** We understand that it can sometimes be difficult to pay bills and want to set up a payment plan that will work for you. If your account is more than 60 days past due, we will contact you by phone. If your account is 90 days past due and no payment has been made, you will receive a letter requesting payment. If your account still remains unpaid, we must refer your account to a collection agency and you may be dismissed from our practice. Should this happen, you will be responsible for any collection and court fees attached to your delinquent account, and you will be notified by mail that you have 30 days to find alternative medical care. During that 30 day period, our providers will provide only emergency care.

I have read and understand the above payment policies and agree to abide by them.

Patient Name:	
Patient (18 years or older) or Parent/Guardian Signature:	
Date:	Relationship to Patient:
Guarantor's SSN:	Guarantor's DOB:

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Patient Portal Sign-Up

The patient portal will allow you to communicate securely with our office anytime that is convenient for you. Through the portal, you can request non-urgent appointments, medication refills, review your lab work and appointment information, and message providers. We encourage you to take advantage of the patient portal to partner with us in your health care. However, if you require urgent medical care, please contact our office by phone instead of via the patient portal.

First and Last Name of Portal Account Holder:
Email Address of Portal Account Holder:
Last 4 Digits of the Portal Account Holder's SSN:
Physical Address of Portal Account Holder:
Phone Number of Portal Account Holder:
Minors and Dependents for Whom Portal Account Holder Requests Access: (formal guardianship documents may be required)

Names	DOB

I grant permission for Village Health, Inc. to create a patient portal account for my household.

Patient (18 years or older) or Parent/Guardian Signature:	
Date:	Relationship to Patient:

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Informed Consent for Telemedicine

Telemedicine uses electronic communications to let patients and health care providers at different locations share medical information for the purpose of improving patient care. The information may be used to diagnosis, therapy, follow-up, and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging date and will include measures to safeguard the data and to ensure the integrity against intentional or unintentional corruption

Expected Benefits

- Improved access to medical care by enabling a patient to remain at a remote site while the physician is at distant/other sites
- More efficient medical evaluation and management
- Obtaining the expertise of a distant specialist

Possible Risks

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the health care provider and/or consultant;
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions, allergic reactions, or other judgement error

By signing this form I consent to and understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that the provider will determine whether the condition being diagnosed or treated is appropriate for a telemedicine visit.
3. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
4. I understand that either my healthcare provider or I may discontinue the telemedicine visit if it is felt that the audio or video connections are not adequate for the situation.
5. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee.
6. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. A representative of Village Health, Inc. has explained the alternatives to my satisfaction.
7. I understand that telemedicine may involve electronic communication of my personal medical information to other medical providers who may be located in other areas, including out of state.
8. I understand that it is my duty to inform a representative of Village Health, Inc. of electronic interactions regarding my care that I may have with other health care providers.
9. I understand that neither the treating provider nor I will create an audio/video recording of any of our telemedicine encounters
10. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
11. I permit transmissions for prescription refills, appointment scheduling, and/or patient education to be executed using telemedicine technology.

I have read and understand the information provided above regarding telemedicine. I have had the opportunity to ask questions about this information. All of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care. I authorize Village Health, Inc. to use telemedicine in the course of my diagnosis and treatment.

Patient Signature:	Date:
Witness:	Date:
Provider Signature:	Date:

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Notice of Privacy Practices for Village Health

This notice describes how medical information about you may be used and disclosed by Village Health and how you can get access to this information. We encourage you to read it carefully.

How We Use and Disclose Your Medical Information

At Village Health, we are committed to your confidentiality and honoring the trust that you place in us as your medical providers. Our release of your medical information is typically to use or share your health information in the following ways.

Treat you: We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services or the quality of care provided.

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

Other Ways We May Use and Disclose Your Medical Information

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Public health and safety issues: We can share health information about you for certain situations such as:

- Reporting information to prevent or control disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research: We can use or share your information for health research.

Electronic Health Records and Health Information Exchanges: We use an electronic health record to store and retrieve much of your health information. One of the advantages of the electronic health record is the ability to share and exchange health information among health care providers on your medical team. When we enter your information into the electronic medical record, that information may be shared as permitted by law using shared clinical databases and health information exchanges. We may also receive information about you from other health care providers involved with your care by using shared databases or health information exchanges, including the Vermont Health Information Exchange (VHIE) or the Healthcare Information Xchange of New York (Hixny). We may seek your consent to access medical information from your other health care providers that is available on VHIE or Hixny. For information about VHIE, see www.vitl.net. For

information about Hixny, see hixny.org. If you have questions or concerns about this sharing of information, please contact us.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. *Respond to organ and tissue donation requests:* We can share health information about you with organ procurement organizations. *Work with a medical examiner or funeral director:* We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims in compliance with state Worker's Compensation Statute
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena. We may disclose your health information to law enforcement officials as required by law or disclose limited health information for identification and location purposes or to assist in criminal investigations.

Certain Health Information

Some types of health information are protected by additional laws, including Vermont or New York privacy laws. These laws may limit whether and how we share different kinds of information:

- In New York, HIV-related information (e.g. information regarding HIV testing, test results, or HIV treatment) can only be disclosed with special written authorization. We may share HIV-related information about your treatment as past of public health activities and as otherwise permitted by law.
- Substance abuse treatment program records
- Certain records of minors
- Certain mental health records

Your Rights

When it comes to your health information, you have certain rights:

*Get an electronic or paper copy of your medical record:*You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. At your request, we will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us using the contact information at the top of the page. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts (if we contact you for fundraising efforts, you can tell us not to contact you again)

We never share your information for marketing purposes, sale of your information, or most sharing of psychotherapy notes unless you give us written permission.

Our Responsibilities
We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing.
- If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. This Notice describes the privacy policies of Village Health, Inc. that became effective on September 1, 2019.