Middlebury Family Health
1330 Exchange St Suite 201
Middlebury, VT 05753
P) 802-388-1500
F) 802-388-0441

Eileen Doherty-Fuller, MD
Katie Miller, MD Linn Larson, MD
Jean Andersson-Swayze, MD
Peter Wilhelm, MD Lena Wasmus, FNP
Kate Shaper, DNP

Welcome to Middlebury Family Health.

As a new patient, please plan to spend up to 1 hour in our office for the initial office visit. The doctor will review your medical history and perform a physical examination.

Included in this packet are all the necessary forms needed for your initial visit**. The contents of the packet and all previous records must be received within one week of receiving packet**. This requirement helps minimize your waiting time and assures that all necessary medical record information can be processed to the doctor. Please be sure to complete the Authorization to Receive Records form included in your packet. The packet can be dropped off at the office, mailed to: Middlebury Family Health Attn: Medical Records, 1330 Exchange Street STE 201,Middlebury VT 05753. You may also fax to: 802-388-0441.

PLEASE BE ADVISED WE WILL NOT CONSIDER PRESCRIBING NARCOTICS without thorough review of your old medical records and speaking to your previous physician first. You will therefore need to get your old records to us prior to your initial visit.

WHAT TO BRING WITH YOU TO YOUR APPOINTMENT

1) Medical insurance card(s) if applicable
2) A list of questions and/or concerns for the Doctor and his/ her staff to answer
3) Your method of payment, we accept cash, checks, and visa/master card & Discover
4) Immunization history(from pharmacies, PCP, Hospital, etc)

If your insurance plan requires a co-payment associated with office visits, we ask for that to be paid at the time of your appointment. If you do not have insurance coverage, we ask that you pay in full at the time of your visit. For your convenience we offer check, cash, Visa,Master Card & Discover as payment options. Our practice provides equal access to all of our patients regardless of source of payment.

We look forward to seeing you on ____________ @ __________.

Two days prior to your visit you will receive a reminder call to confirm your appointment. Should you need to cancel or reschedule your appointment for any reason, please give **24-hour notice**. **We ask that you arrive 15 min early to check in for the first time.**

Please feel free to contact the office with any questions.

Thank you for choosing Middlebury Family Health.

I have read the above and agree to the terms:

Signature: ______________________________________ Date: _______________

Middlebury Family Health

1330 Exchange Street Suite 201
Middlebury, VT 05753
P) 802-388-1500
F) 802-388-0441

Eileen Fuller, MD Katie Miller, MD
Linn Larson, MD Jean Andersson-Swayze, MD
Peter Wilhelm, MD Lena Wasmus, FNP
Kate Shaper, DNP

PATIENT AUTHORIZATION FORM TO RECEIVE RECORDS

I hereby authorize ____ at the following address:

____

Phone Number: ________________________FAX Number:______________________________

to release my health record or the specific information described below only to the parties described below.

SPECIFIC INFORMATION TO BE RELEASED:

( ) All Records **(may include all of your records including: office notes, medication list, problem lists, immunizations, labs, last colonoscopy, last mammogram, Advance Directive/Power of Attorney, Xrays and other important correspondence)** In addition it may include mental health notes, alcohol/drug abuse, STD, HIV, and genetic testing

( ) Other: ____

REASON FOR RELEASE:

( ) Relocating
( ) Legal Request
( ) Disability Determination
( ) Changing Physician due to insurance
( ) Insurance Company
( ) Dissatisfied with my Care
( ) Other: ____

INFORMATION BEING RELEASED TO:

Middlebury Family Health
1330 Exchange St Suite 201
Middlebury, VT 05753

Phone: 802-388-1500
Fax: 802-388-0441

This authorization shall remain in effect from the date signed below until: ________________________
(Expiration date or event)

Middlebury Family Health does not require completion of this form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party, it may result in the cancellation of those services. (If authorization to release the information to that third party is not provided).

I understand that I may inspect or copy my PHI (protected health information) to be released. I may revoke this authorization in writing by contacting this office. Information sent may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.

PATIENT NAME: ____ DOB: __________________

PATIENT SIGNATURE: ____________________________________ DATE: _________________

Relationship to patient if not signed by patient: ____

MIDDLEBURY FAMILY HEALTH **PATIENT REGISTRATION**

Patient Name:	Age:	DOB:

Mailing Address:	Male or Female	

City, State, Zip:	E-mail:

Home Phone:	Work Phone:	Cell Phone:
☐ Check If Daytime Phone	☐ Check If Daytime Phone	☐ Check If Daytime Phone

(If Under 18) Mother's Name:	(If Under 18) Father's Name:
☐ Check if Emergency Contact	☐ Check if Emergency Contact

(If Applicable) Legal Guardian:	(If Applicable) Foster Parent(s):
☐ Check if Emergency Contact	☐ Check if Emergency Contact

Primary Insurance Name:	Policy Holder & DOB:
ID Number:	Group #

Secondary Insurance Name:	Policy Holder & DOB:
ID Number:	Group #

Third Insurance Name:	Policy Holder & DOB:
ID Number:	Group #

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I request that payment of authorized medical benefits be made on my behalf to Middlebury Family Health for any services furnished to me, including physician services. I authorize any holder of medical information about me to release my insurance carrier or intermediaries any information for this or a related claim.

Signature ______________________________ Date ________________

Patient or legal guardian

Adult Health Database

Center:

Name:

D.O.B.

Patient #

Date:_______________ Maiden Name_______________

Phone: Day:_______________ Evening:_______________

Patient Name_______________

Address_______________

Birthplace_______________ Ethnic Background_______________

Emergency Contact's Name:_______________ Phone #_______________

Name of Health Care Proxy/Durable Power of Attorney for Health Care_______________ Phone #_______________

HOUSEHOLD MEMBERS

Name	Age	Relationship	Name	Age	Relationship

SOCIAL HISTORY Education Level_______________ Occupation_______________

Marital Status_______________ Sexual Orientation ☐ heterosexual ☐ bisexual ☐ homosexual ☐ other

Military History_______________

Religion_______________ Hobbies_______________

PERSONAL HEALTH HISTORY List below, in date order, any hospitalizations, surgeries, transfusions/needlesticks, history of TB, major illnesses and/or accidents:

Nature of Problem	Date

ADVANCE DIRECTIVE

Are you familiar with advance directives? ☐ yes ☐ no
Have you prepared an advance directive, (living will, health care proxy)? ☐ yes ☐ no
Have you given us a copy of your advance directive to put in your medical record? ☐ yes ☐ no
In order for your provider to follow your directive, we encourage you to send us a copy.

SAFETY

Do you regularly use:

Seatbelt ☐ yes ☐ no
Helmet (bicycle or motorcycle) ☐ yes ☐ no
Ear/Eye Protection (when needed) ☐ yes ☐ no
Sunscreen ☐ yes ☐ no
Are there smoke detectors in your home? ☐ yes ☐ no

Do you have guns in your home? ☐ yes ☐ no
Are you or have you been a victim of abuse? ☐ yes ☐ no
Would you like help? ☐ yes ☐ no

Order #1397 981598N (9/98)

MEDICATIONS

What prescription **and** nonprescription medicines are you taking on a regular basis? (Include vitamins, aspirin, laxatives, birth control pills, injectables, alternative medicines etc.) Please bring prescription bottles with you at time of appointment.

Prescription Name	Dose	Frequency	**Non** Prescription Name	Dose	Frequency

ALLERGIES/ SENSITIVITIES

Are you sensitive to any medication or substance? ☐ Yes ☐ No ☐ Don't Know

Drug Name	Reaction	Substance Name	Reaction

PERSONAL HABITS

Tobacco Use/Exposure:

Do you smoke cigarettes? ☐ No ☐ Yes

what kind?________ how much?________ since when________

Do you want to quit? ☐ Yes ☐ No

Do you chew tobacco? ☐ No ☐ Yes

Did you smoke in the past? ☐ No ☐ Yes — date quit________

Are you currently exposed to second hand smoke? ☐ No ☐ Yes — where________

Substance Use:

Do you drink alcohol? ☐ No ☐ Yes

what?________ how often?________ how much?________

If **yes,**

- has drinking ever been a problem in any area of your life? (family, work, driving, etc.) ☐ No ☐ Yes________
- have you ever had a loss of memory or blackout while, or after, drinking? ☐ No ☐ Yes________
- do you feel that your health would be better if you decreased or stopped drinking? ☐ No ☐ Yes________

Have you ever used drugs such as steroids, marijuana or IV drugs? ☐ No ☐ Yes________

Have you ever been treated for a drinking or a drug problem? ☐ No ☐ Yes________

Other:

Do you exercise regularly? ☐ Yes ☐ No If so, how?________

Do you use laxatives regularly? ☐ No ☐ Yes

Do you have concerns about an eating disorder? ☐ No ☐ Yes

Do you drink coffee, tea, or soda (caffeine)? ☐ No ☐ Yes — how much daily?________

Do you follow a special diet such as:

☐ low cholesterol ☐ high protein ☐ high fiber ☐ diabetic

☐ low fat ☐ lactose free ☐ low salt ☐ vegetarian

☐ other, please describe________

IMMUNIZATION STATUS

Date(s) of immunization or disease

Immunization	Date(s)	Immunization	Date(s)
Tetanus		Rubella	
Influenza		MMR (measles/mumps/rubella)	1____ 2____
Hepatitis B series		BCG (tuberculosis immunization)	
Polio		Varicella (chicken pox)	
Pneumovax		Tb skin test	
Measles		Other	

HEALTH MAINTENANCE

Please list the last date you had any of the following:

	DATE	RESULT
Physical/Health Maintenance Exam		
Eye exam		
Hearing exam		
Dental exam		
Cholesterol check		
Stool test for blood		
Sigmoidoscopy		
Pap smear		
Mammogram		

GENITO/REPRODUCTIVE

Female:

Age periods began?________ How many days do your periods last?________

How often do they occur?________ When did your last period start (date)________

If your period has stopped, give the year of your last period________

Number of pregnancies________ Number of births________ Number of miscarriages ________

Number of elective abortions________ Type of birth control used now________

Did your mother take DES or hormones while pregnant? ☐ no ☐ yes

Have you ever been treated for: venereal disease/sexually transmitted disease? ☐ no ☐ yes ________

Have you had multiple sexual partners? ☐ no ☐ yes

Currently/ever have hormonal replacement therapy? ☐ no ☐ yes________

Have you ever had an abnormal pap? ☐ no ☐ yes________

Have you had a colposcopy? ☐ no ☐ yes________

Are you known to have cystic breasts? ☐ no ☐ yes

Have you ever had an abnormal mammogram? ☐ no ☐ yes ________

Do you regularly practice breast self examination? ☐ yes ☐ no

Do you feel you have a problem with any of the following? (Please specify briefly):

Heavy flow ________

Bleeding between periods ________

Bleeding or spotting after intercourse________

Recurrent vaginal discharge or itch________

Infertility ________

Menopausal symptoms________

Premenstrual symptoms________

Sexual function________

Male:

Do you perform testicular self exam? ☐ yes ☐ no

Have you had multiple sexual partners? ☐ no ☐ yes

Have you ever been treated for a sexually transmitted disease? ☐ no ☐ yes ________

Have you had a vasectomy? ☐ yes ☐ no

Do you have a problem with any of the following?

Infertility ☐ yes ☐ no

Scrotum or testicles ☐ yes ☐ no

Decrease in stream ☐ yes ☐ no

Prostate ☐ yes ☐ no

Impotence/sexual function________ ☐ yes ☐ no

Nighttime urination ________ ☐ yes ☐ no

Change in pattern of urination ________ ☐ yes ☐ no

FAMILY HISTORY

Family Health History	Living Age	Deceased Age	Cause
Father			
Mother			
Spouse			
Brother/Sister 1			
2			
3			
4			
Children 1			
2			
3			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Check if problem occurs in family	
Heart Disease	Emotional Problem
High Cholesterol	Depression
High Blood Pressure	Alcohol Use
Cancer	Suicide
Diabetes	Seizures
Thyroid Problem	Stroke
Bleeding problem	Migraines
Anemia	Mental Retardation
Sickle Cell	Allergy
Asthma	Glaucoma
TB	Kidney Disease
Gout	Ulcer
Arthritis	Other

Genogram (for your provider's use only)

- Male
- Female
- or Death
- or Index Patient or Proband
- Two Normal Males
- Three Normal Females
- Four Births, Sex Unspecified or Unknown
- Spontaneous Abortion
- Induced Abortion
- Pregnancy - Child in Utero
- Dizygotic Twins
- Monozygotic Twins
- Adopted
- '38 Year of Birth
- David Name
- 48 Age (or Year) at Death
- '30-'48 Year of Birth and Death
- CA Cause of Death
- 1969 Marriage and Year
- 1975 Separation and Year
- 1982 Not Married, Year Started Living Together
- 1969 Solid or Dashed Line Indicating Individuals Living Together
- Conflictual Relationship
- Distant Relationship
- Close Relationship
- Overly Close Relationship
- Dominant Relationship
- Marital Discord
- Marital Discord and Girlfriend
- Divorce - Mother has Custody of Two Girls
- '75 '80 '88 '82 '75 Married Couple Each with Multiple Spouses

Middlebury Family Health
Payment Policy
Effective 01/02/17

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. If you do not have any insurance you will receive a 10% discount on your medical services. If you do not have any insurance and you pay in full at the time of service, you will receive a 20% discount.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter requesting payment. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Middlebury Family Health requires that patients give us 24 hours notice prior to canceling appointments. Patients may be dismissed from the practice for habitually missing appointments. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_______________________________ _____________________

Signature of patient or responsible party **Date**

PATIENT NON-DISCRIMINATION POLICY

"Any individual shall not be discriminated against because of race, color, creed, religion, sex, age, sexual preference, national origin, citizenship, marital status, disability, veteran status or any other status or characteristic protected under applicable federal, state or local laws. Acts of and/or harassment based on any of those factors are totally inconsistent with our philosophy of doing business and will not be tolerated at any time."

Affordable Care Act Grievance Procedure
It is the policy of Middlebury Family Health not to discriminate on the basis of race, color, national origin, sex, age or disability. Middlebury Family Health has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) and its implementing regulations at 45 C.F.R. pt. 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of Stacy Ladd, Practice Manager- Section 1557 Coordinator, 44 Collins Drive Suite 201 Middlebury VT 05753, 802-388-1500 x232, Fax: 802-388-0441, sladd@middfam.comcastbiz.net who has been designated to coordinate the efforts of Middlebury Family Health to comply with Section 1557. Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for Middlebury Family Health to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

• Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action. • A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

• The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of Middlebury Family Health relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

• The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies. • The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the (Administrator/Chief Executive Officer/Board of Directors/etc.) within 15 days of receiving the Section 1557 Coordinator's decision. The (Administrator/Chief Executive Officer/Board of Directors/etc.) shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or

phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Toll Free Call Center: 1-877-696-6775
Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination. Middlebury Family Health will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.
Dated:10/13/16 **Stacy Ladd, Practice Manager**

Language Services:

ATTENTION: If you speak language other than English, language assistance services, free of charge, are available to you at our office. Please call 802-388-1500 for more information

Spanish:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-368-1019 (TTY: 1-800-368-1019).

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-368-1019

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-368-1019

Bosnian:
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite -Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-368-1019

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-368-1019

Italian:
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-368-1019

Hindi:
ध्यान द□: य□द आप □हदी बोलते ह □तो आपके िलए मुफ्त म□ भाषा सहायता सेवाएं उपलब्ध ह।□ 1-800-368-1019 पर कॉल कर□।

Urdu:
ل ۔ کا ں ب ہی ں دستیا ت می ت مف ی خدما د ک ی مد ن ک و زبا پ ک و آ ، ت ے ہیں و بولت پ ارد ر آ :اگ خبردار ں کری 1-
800-368-1019

Gujarati:
ચુના: જો તમે જરાતી બોલતા હો, તો િન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન રો 1-
800-368-1019

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-368-1019

Portuguese:
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para
1-800-368-1019

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。まで、お電話にてご連絡ください。1-800-368-1019

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số
1-800-368-1019

Thai:
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-368-1019

Arabic:
م ل برق .اتصل ك بالمجان ر ل ة تتوا ة اللغوي ت المساعد ن خدما ، فإ ر اللغة ث اذك ت تتحد ا كن :إذ 1 -xxx-xxx-xxxx م)رق
م والبكم الص هات :1-800-368-1019 ملحوظة

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-800-368-1019 (телетайп: 1-800-368-1019

Napali:
ध्यान दनुहोस: तपाइले नेपाल बोल्नहन्छ भन तपाइको निम्त भाषा सहायता सवाहरू न:शल्क रूपमा उपलब्ध छ । फोन गनुहोसर् 1-800-368-1019 (टटवाइ: 1-800-368-1019