

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: \_\_\_\_\_

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## 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:

- |   |  |
|---|--|
| <input type="checkbox"/> Relocating               | <input type="checkbox"/> Changing Physician due to insurance |
| <input type="checkbox"/> Legal Request            | <input type="checkbox"/> Insurance Company                   |
| <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Dissatisfied with my Care           |
| <input type="checkbox"/> Other: _____             |  |

### INFORMATION BEING RELEASED TO:

|                            |                     |
|----------------------------|---------------------|
| Middlebury Family Health   | Phone: 802-388-1500 |
| 1330 Exchange St Suite 201 | Fax: 802-388-0441   |
| Middlebury, VT 05753       |                     |

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**

|                      |             |             |
|----------------------|-------------|-------------|
| <b>Patient Name:</b> | <b>Age:</b> | <b>DOB:</b> |
|----------------------|-------------|-------------|

|                         |                       |
|-------------------------|-----------------------|
| <b>Mailing Address:</b> | <b>Male or Female</b> |
|-------------------------|-----------------------|

|                          |                |
|--------------------------|----------------|
| <b>City, State, Zip:</b> | <b>E-mail:</b> |
|--------------------------|----------------|

|   |   |   |
|---|---|---|
| <b>Home Phone:</b><br><input type="checkbox"/> Check If Daytime Phone | <b>Work Phone:</b><br><input type="checkbox"/> Check If Daytime Phone | <b>Cell Phone:</b><br><input type="checkbox"/> Check If Daytime Phone |
|---|---|---|

|  |  |
|--|--|
| <b>(If Under 18) Mother's Name:</b><br><input type="checkbox"/> Check if Emergency Contact | <b>(If Under 18) Father's Name:</b><br><input type="checkbox"/> Check if Emergency Contact |
|--|--|

|   |   |
|---|---|
| <b>(If Applicable) Legal Guardian:</b><br><input type="checkbox"/> Check if Emergency Contact | <b>(If Applicable) Foster Parent(s):</b><br><input type="checkbox"/> Check if Emergency Contact |
|---|---|

|                                |                                 |
|--------------------------------|---------------------------------|
| <b>Primary Insurance Name:</b> | <b>Policy Holder &amp; DOB:</b> |
| <b>ID Number:</b>              | <b>Group #</b>                  |

|                                  |                                 |
|----------------------------------|---------------------------------|
| <b>Secondary Insurance Name:</b> | <b>Policy Holder &amp; DOB:</b> |
| <b>ID Number:</b>                | <b>Group #</b>                  |

|                              |                                 |
|------------------------------|---------------------------------|
| <b>Third Insurance Name:</b> | <b>Policy Holder &amp; DOB:</b> |
| <b>ID Number:</b>            | <b>Group #</b>                  |

**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

# Initial History Questionnaire

Name \_\_\_\_\_

ID NUMBER \_\_\_\_\_

FORM COMPLETED BY \_\_\_\_\_

DATE COMPLETED \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

AGE \_\_\_\_\_

## Household

Please list all those living in the child's home.

| Name | Relationship to child | Birth date | Health problems |
|------|-----------------------|------------|-----------------|
|      |                       |            |                 |
|      |                       |            |                 |
|      |                       |            |                 |
|      |                       |            |                 |
|      |                       |            |                 |
|      |                       |            |                 |
|      |                       |            |                 |

Are there siblings not listed? If so, please list their names and ages and where they live. \_\_\_\_\_

If mother and father are not living together or if child does not live with parents, what is the child's custody status? \_\_\_\_\_

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? \_\_\_\_\_

## Birth History

Birth weight \_\_\_\_\_

Was the baby born at term? \_\_\_\_\_ Early? \_\_\_\_\_ Late? \_\_\_\_\_

If early, how many weeks' gestation? \_\_\_\_\_

Did mother have any illness or problem with her pregnancy?  
 Yes  No Explain \_\_\_\_\_

During pregnancy, did mother  
 Smoke  Yes  No Drink alcohol  Yes  No  
 Use drugs or medications  Yes  No  
 What \_\_\_\_\_ When \_\_\_\_\_

Was the delivery  Vaginal?  Cesarean?

If cesarean, why? \_\_\_\_\_

Did your baby have any problems right after birth?  
 Yes  No Explain \_\_\_\_\_

Was initial feeding  Breast?  Bottle?

Did your baby go home with mother from the hospital?  
 Yes  No Explain \_\_\_\_\_

## General

- Do you consider your child to be in good health?  Yes  No Explain \_\_\_\_\_
- Does your child have any serious illness or medical condition?  Yes  No Explain \_\_\_\_\_
- Has your child had serious injuries or accidents?  Yes  No Explain \_\_\_\_\_
- Has your child had any surgery?  Yes  No Explain \_\_\_\_\_
- Has your child ever been hospitalized?  Yes  No Explain \_\_\_\_\_
- Is your child allergic to any medicines or drugs?  Yes  No Explain \_\_\_\_\_

## Development

- Are you concerned about your child's physical development?  Yes  No Explain \_\_\_\_\_
- Are you concerned about your child's mental or emotional development?  Yes  No Explain \_\_\_\_\_
- Are you concerned about your child's attention span?  Yes  No Explain \_\_\_\_\_
- If your child is in school:  
 How is his/her behavior in school? \_\_\_\_\_  
 Has he/she failed or repeated a grade in school? \_\_\_\_\_  
 How is he/she doing in academic subjects? \_\_\_\_\_  
 Is he/she in special or resource classes? \_\_\_\_\_



## Family History

Have any family members had the following:

|   |                              |                             |           |                |
|---|------------------------------|-----------------------------|-----------|----------------|
| Deafness                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Nasal allergies                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Asthma                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Tuberculosis                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Heart disease (before 50 years old)       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| High blood pressure (before 50 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| High cholesterol                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Anemia                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Bleeding disorder                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Liver disease                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Kidney disease                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Diabetes (before 50 years old)            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Bed-wetting (after 10 years old)          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Epilepsy or convulsions                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Alcohol abuse                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Drug abuse                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Mental illness                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Mental retardation                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Immune problems, HIV, or AIDS             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Additional family history                 | _____                        |                             |           |                |

## Past History

Does your child have, or has he/she ever had:

|   |                              |                             |               |
|---|------------------------------|-----------------------------|---------------|
| Chickenpox  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____    |
| Frequent ear infections                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Problems with ears or hearing                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Nasal allergies   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Problems with eyes or vision                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Asthma, bronchitis, bronchiolitis, or pneumonia           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Any heart problem or heart murmur                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Anemia or bleeding problem                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Blood transfusion   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Frequent abdominal pain                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Constipation requiring doctor visits                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Bladder or kidney infection                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Bed-wetting (after 5 years old)                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| (For girls) Has she started her menstrual periods?        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____    |
| (For girls) Are there problems with her periods?          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Any chronic or recurrent skin problem (acne, eczema, etc) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Frequent headaches  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Convulsions or other neurologic problem                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Diabetes  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Thyroid or other endocrine problem                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Any other significant problem                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Use of alcohol or drugs                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |

## 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](mailto: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 दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-368-1019 पर कॉल करें।



**Urdu:**

ل۔ کان بیوں دستیات می ت مفی خدمات کی مدد کوزیبا پک و آ، تے بیوں بولت پ اردر آ: اگ خبرداروں کری 1-800-368-1019

**Gujarati:**

પચુના: જો તમે ગજરાતી બોલતા હો, તો િન:ભક્ષુ ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન પરો 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. اتص لك بالمجان ر ل ة تتوا ة اللغوي ت المساعد ن خدما ، فإر اللغة ث اذك ت تتحد ا كن : إذ 1-xxx-xxx-xxxx م برق 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)

**Nepali:**

ध्यान ढदनुहोसः तपाइले नेपाल ढोल्नहन्छ भन तपाइको ढनिम्त भाषा सहायता सवाहरू ढनःशल्क रूपमा उपलब्ध छ । फोन गनुहोसर् 1-800-368-1019 (ढटढटवाइः 1-800-368-1019)