North Country Primary Care
Where caring runs deep. Newport • Barton • Orleans

Welcome to North Country Primary Care

- **If you take daily medications, please bring them with you to your appointments**. The nurse will review your medications with you during your visit time.
- **Call us first!** We save time every day in our schedules for sick patients. Please let us know as early in the day as possible when you need our services so we can schedule you for a visit.
- **We are an NCQA-recognized Patient Centered Medical Home**; see our brochure for details on this.
- We have a **patient portal** which allows you to access your personal health information 24 hours a day and 7 days a week. You can **request appointments, prescription renewals as well as send email messages**, saving you the time of making a phone call.
- **Please call us as soon as possible when you're unable to keep a scheduled appointment**. This allows us to use that time for another patient.
- **Please arrive on time for your appointment**. This allows the nurse to complete the nursing portion of your visit and will allow you more time with your provider.
- **We try to stay on schedule**, but we also will spend whatever time is necessary to evaluate your problem and that puts us behind schedule at times.
- **Co-payments are due at the time of your visit** unless prior arrangements have been made. Also, please bring your insurance card with you.
- Patients and staff can have allergies. **Please don't wear heavy perfumes or heavy scents** as that might cause problems for others.
- **If you are ill, please request a mask from our receptionist**. This helps protect other patients and staff from getting sick with the same illness.

Barton Orleans			Newport		
Clinic Hours	7:40 a.m. to 4 p.m.	Monday - Friday	Clinic Hours	7:40 a.m. to 4:00 p.m	Monday - Friday
Phones	8 a.m. to 4:00 p.m.	Monday – Friday	Phones	8:00 a.m. to 4:00 p.m.	Monday – Friday

Newport
186 Medical Village Drive
Newport, VT 05855
Phone 802-334-3520
Fax 802-334-3512

Mental Health Services
Kelly Hensley, DNP

Barton Orleans
488 Elm Street
Barton, VT 05822
Phone 802-525-3539
Fax 802-525-3088

Megan Batchelder, MD
Elizabeth Yasewicz, PA-C
Andrea Dale, MD
Victoria Martin, PA-C

Patrick Keith, MD
Andrea Van Woert, FNP
Stephanie Amorosa, MD
Rory Carr, FNP

John Lippmann, MD
Wesley Nutter, FNP
Alexandra Peters, FNP
Jared Leavitt, PA-C

Megan Garrigan, PA-C
Carlos Alfaraz, MD
Hailey Bonneau, FNP

North Country Hospital
Where caring runs deep.

Date:_____

Patient Registration

(Please print neatly)

Welcome to North Country Hospital. Please take the time to fill out this form as accurately as possible so we can best address your needs. The information you provide on this form is confidential and protected by Federal and State law, and cannot be disclosed without your consent as described in the HIPAA Notice of Privacy Practices.

Legal Name* First Middle Initial Last

Preferred Name:

Social Security #:

Sex at Birth (please check one)* **[ ] Female [ ] Male**
*Most insurances companies require that we bill under legal name and sex shown on insurance card.

Preferred Pronouns: [ ] He/Him/His
[ ] She/Her/Hers [ ] They/Them/Theirs

Date of Birth:
Month Day Year
/ /

Relationship Status:
[ ] Single [ ] Married [ ] Divorced [ ] Civil Union
[ ] Separated [ ] Widowed [ ] Declined

Employment Status: [ ] Employed Employer:_____
[ ] Unemployed [ ] Self Employed [ ] Child/Student [ ] Retired - Date:___/____/_____ [ ] Disabled [ ] Other

Parents/Guardians Name:	Date of Birth	Best Phone Number	Relationship to you	Child lives with
_____	____/____/____	( ) -	_____	☐
_____	____/____/____	( ) -	_____	☐

Mailing address: **City** **State** **Zip**

Physical address (if different from above) **City** **State** **Zip**

Temporary/Seasonal address: **City** **State** **Zip**

Home phone:	**Cell phone:**	**Work phone:**	**Best number to use:**
( )	**( )**	**( )**	[ ] Home [ ] Cell [ ] Work
Okay to leave a message?	Okay to leave a message?	Okay to leave a message?	
[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	

Email address*
*Although the chances are low that unsecured e-mail messages between you and NCH could be intercepted, the risk exists.

Preferred method of contact: [ ] Letter [ ] Home phone [ ] Cell phone [ ] Work phone [ ] Text [ ] Email*

Emergency Contact Name: Date of Birth Best phone number Relationship to you

Primary Care Provider:

Primary Care Provider Address (if not NCH provider):

Do you have a dentist?
[ ] Yes [ ] No

Name of Dentist if yes:

PAYMENT AND INSURANCE INFORMATION **Check if:** [ ] Self-Pay [ ] Uninsured
If uninsured, would you like to meet with Navigator? [ ] Yes [ ] No

Name of Primary Medical Insurance Carrier: **ID #:** _____

Policy Holder: [ ] Patient [ ] Spouse
[ ] Parent [ ] Other _____

Name and Date of Birth of Policy Holder:

Name of Secondary Medical Insurance Carrier: **ID #:** _____

Policy Holder: [ ] Patient [ ] Spouse
[ ] Parent [ ] Other _____

Name and Date of Birth of Policy Holder:

We collect the following data for reporting purposes only. Thank you for your cooperation in completing this portion.

Primary Language: [ ] English [ ] Spanish
[ ] French [ ] Other_____

Interpreter needed: [ ] Yes [ ] No

Race:
[ ] White [ ] Black/African American [ ] Asian
[ ] American Indian/Alaska Native
[ ] Native Hawaiian/ Pacific Islander
[ ] Other [ ] Choose not to disclose

Ethnicity:
[ ] Hispanic, Latino or Spanish origin
[ ] Not Hispanic, Latino, or Spanish Origin
[ ] Choose not to disclose

Sexual Orientation:
[ ] Lesbian, gay or homosexual [ ] Straight or heterosexual
[ ] Bisexual [ ] Something else
[ ] Don't know [ ] Choose not to disclose

Gender Identity:
[ ] Male [ ] Female
[ ] Transgender Male/FTM [ ] Transgender Female/MTF
[ ] Genderqueer, neither exclusively male or female
[ ] Other [ ] Choose not to disclose

Living Situation: What is your living situation today?
[ ] I have a steady place to live
[ ] I have a place to live today, but I am worried about losing it in the future.
[ ] I don't have a steady place to live

Food: Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, Sometimes, or Never true for you and your household in the last 12 months.

Within the past 12 months, you were worried that your food would run out before you got money to buy more
[ ] Often true
[ ] Sometimes true
[ ] Never true

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more
[ ] Often true
[ ] Sometimes true
[ ] Never true

Transportation: In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?
[ ] Yes
[ ] No

Safety: Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.
How often does anyone, including family and friends:

Physically hurt you?	**Insult or talk down to you?**	**Threatened you will harm?**	**Scream or curse at you?**
[ ] Never	[ ] Never	[ ] Never	[ ] Never
[ ] Rarely	[ ] Rarely	[ ] Rarely	[ ] Rarely
[ ] Sometimes	[ ] Sometimes	[ ] Sometimes	[ ] Sometimes
[ ] Fairly often	[ ] Fairly often	[ ] Fairly often	[ ] Fairly often
[ ] Frequently	[ ] Frequently	[ ] Frequently	[ ] Frequently

Financial: How hard is it for you to pay for the basics like food, housing, medical care, and heating? Would you say it is:
[ ] Very hard [ ] Somewhat hard [ ] Not hard at all

Are you interested in having a community health worker reach out to you to discuss potential community resources to help with any of the above? [ ] Yes [ ] No

Looking to have 24-hour access to your personal health record, request appointments, request prescription refills or message your provider? Let us send you an invitation to join our portal.
[ ] Yes, send invite to the following email _____
[ ] No

For new patients:
Do you have a preference for your primary care provider? _____

North Country Hospital
Where caring runs deep.

Permission for Disclosure of Medical Information

(Please print clearly)

Today's Date: _____

LAST NAME: _____ FIRST NAME: _____ DATE OF BIRTH: _____

PREFERRED METHOD TO CONTACT YOU: HOME WORK CELL OTHER: _____

HOME **PHONE:** _____ WORK PHONE: _____ CELL PHONE: _____

To protect your privacy, please help us know the contact person(s) you allow us to talk to. Please list your emergency contact first. **If this is a minor child, please provide the names and information of all parents and guardians.**

NAME	PHONE NUMBER	RELATIONSHIP
Emergency Contact:		

Can we leave a message on an answering machine: YES NO

Can we leave a message with a person who answers the phone: YES NO

List any information that you do not want released or person(s) to whom you do not want us to give your information:

If this is a minor child, is anyone not allowed to access the child's records or information? YES NO
If yes is circled, please specify below and provide a copy of the court order specifying such.

Patient, Parent or Legal Guardian Signature: _____ Date: _____

☐ Reviewed with no changes Signature: _____ Date: _____

☐ Reviewed with no changes Signature: _____ Date: _____

Rev 5/2024

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New Patient Health Questionnaire

This is a confidential record. Information will not be released without your written permission.

Name: _____ Date of Birth: _____

Local Pharmacy: _____ Location: _____Mail Order Pharmacy: _____

** Do you advance directives? _____ Durable power of attorney? _____ COLST: _____
**** If yes, please bring in a copy.**

Current Medical Problems

Include current symptoms and active health problems

_____

_____

_____

Date of last wellness visit: _____

Allergies

Please list any allergies you may have to medications, pets, environmental, etc.

_____ _____
_____ _____

Immunizations

Last Tetanus Booster _____ Hepatitis B Series _____
Pneumonia Vaccine _____ Influenza Vaccine(s) _____

Family Medical History

Relative	Age (or deceased)	Health Problems (or cause of death)
Father	_____	_____
Mother	_____	_____
Sister(s)	_____	_____
Brother(s)	_____	_____

What diseases run in your family? _____

_____

Social History

Who lives at home with you? _____

Do you feel safe at home? _____ Have you been threatened or hurt? _____

Have you ever been physically, sexually, or emotionally (verbally) abused? _____

Medications

List all medications with dose and frequency. Include non-prescription medications (aspirin, vitamins, etc.)

IMPORTANT: There are potential risks and side effects of long-term narcotic treatment. If you are currently taking a controlled substance, we cannot guarantee this will be continued once establishing with your new primary care provider. This will be determined once your new primary care provider has reviewed your records and assessed your current medical needs.

IMPORTANT: Also include any medications for opiate use disorder.

☐ Check here if no medications

MEDICINE NAME	STRENGTH	DOSING	MEDICINE NAME	STRENGTH	DOSING
EX. Lisinopril	10 mg	One a day			

Health-Related Habits

Do you use tobacco? _____ What form? _____ Daily amount? _____ How long? _____
Have you ever smoked? _____ What year did you quit? _____

Do you drink or have you ever drank alcohol? _____ What kind? _____
Number of drinks per week: _____

Do you use or have you ever used recreational drugs? _____ What kind(s)? _____
How often? _____

Caffeine? _____ Coffee, tea, cola or other? _____ Amount per day: _____

This is a confidential record. Information will not be shared without your written permission.

Our Role as Your Healthcare Team

- Provide you with your choice of healthcare provider
- Partner with you in all healthcare decisions
- Help you set your own self-management goals and action plans
- Coordinate your care with healthcare providers within and outside our office
- Connect you with social support resources in the community
- Use evidence-based guidelines and education to promote wellness and manage acute or chronic conditions
- Respond to your healthcare needs in a timely manner
- Provide the healthcare you need regardless of your insurance coverage

5/2024

Your Healthcare Team

Your healthcare team includes:

- *You and your family*
- *Your healthcare provider*
- *Nurses*
- *Office staff*
- *Care coordinator*
- *Dieticians*
- *Certified Navigators*
  Help you understand and apply for health insurance choices available.

Be Part of the Team!

- Write down your concerns and questions and bring them to your appointment
- Bring all of your medication bottles, including over the counter medications, to each appointment
- Let us know at your appointment if you need prescription refills
- Tell us when you visit other healthcare providers; tell other healthcare providers to be sure to share important health information about you with us
- Partner with us to make good choices and develop healthy habits
- Let us know before your visit if you need interpreter services
- Give us your feedback on the patient satisfaction survey or use the suggestion box in the waiting area
- Sign up for the patient portal for ease of requesting medication refills, appointments and the ability to message your healthcare team

Call Us First

- For common illnesses when you or a family member looks or acts sick
- For problems that need care now
- Annual physicals, immunizations and well child visits
- For evidence-based information on Self-Management activities such as weight management, exercise programs, and quitting smoking.

Visit our webpage at www.nchsi.org for information about our practice and links to reliable health information. Also, ask us about our patient portal which provides requests for on-line medication refills, appointments and many other services.

Newport

Andrea Dale, MD	**(802) 334-3520**
Megan Batchelder, MD	**Fax: (802) 334-3512**
Elizabeth Yasewicz, PA-C	
Victoria Martin, PA-C	
Stephanie Amorosa, MD	
Patrick Keith, MD	
Rory Carr, FNP	
Andrea Van Woert, FNP	
John Lippmann, MD	
Jared Leavitt, PA-C	
Alexandra Peters, FNP	
Wesley Nutter, FNP	

Newport Office Appointment Hours:

Monday – Friday 7:40 am - 4:00 pm

Barton Orleans

Carlos Alfaraz, MD	**(802) 525-3539**
Hailey Bonneau, FNP	**Fax: (802) 525-3088**
Megan Garrigan, PA_C	

Barton/Orleans Office Appointment Hours:

Monday - Friday 7:40 am - 4:00 pm

We have after hours* (nights & weekends) *emergency coverage through the provider on call.
Please call North Country Hospital at ***802-334-7331***; your call will be answered by the hospital operator and directed to the provider on call. Your call will be returned within 1 hour, so leave a number where you can easily be reached.

4/2024

Call Us First!

North Country Primary Care
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- ✓ We know you and your personal health history.
- ✓ We coordinate care between our office, hospital, and specialists.
- ✓ We guide you through the often-confusing healthcare system.
- ✓ We partner with you to manage your chronic conditions such as diabetes, asthma and/or heart disease.

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Return to:
186 Medical Village Dr.
Newport, VT 05855
Phone: 802-334-3520
Fax: 802-334-3512

488 Elm Street
Barton, VT 05822
Phone: 802-525-3539
Fax: 802-525-3088

Protected Health Information Release Authorization

Full Name: _____ Date of Birth: _____

This will authorize _____ Phone: _____ City/State: _____

to disclose my protected health Information to **North Country Primary Care Newport / Barton Orleans** as described for the following purpose:

Transfer of care/coordination of care / sharing care for seasonal residents / Other: _____

Dates of care include: _____ to _____ or _____ All dates or _____ as indicated below

Check all that apply:

- ☒ Discharge Summary **(all within last 2 years)**
- ☐ History & Physical
- ☒ Operative Note(s) **(all within last 2 years)**
- ☒ Consultation(s) **(all within last 2 years)**
- ☒ Progress Note(s) **(all within last 2 years)**
- ☒ X-Ray, Scans, etc. **(all within last 2 years)**
- ☒ Laboratory Data **(all within last 2 years)**
- ☒ E.R. Record(s) **(all within last 2 years)**
- ☒ E.K.G. (s) **(all within last 2 years)**
- ☐ Nurses Note(s)
- ☒ Other: **Problem list, Medications, Allergies**

_____

☐ **All Records** (exceptions noted below)

The information regarding the following areas of treatment will not be released without specific authorization, signified by my initials.

_____ Mental Illness (excluding psychotherapy notes)
_____ Drug or alcohol treatment *
_____ Opiate Use Disorder *
_____ HIV related illness
_____ Hep C

* Federal Confidentiality Law – 42 CFR Part 2 prohibits those receiving information on drug or alcohol treatment from re-disclosing it unless written consent is granted by the patient or otherwise permitted by 42 CFR Part 2.

- I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
- I understand that I MAY REFUSE TO SIGN THIS AUTHORIZATION. I also understand that North Country Hospital shall not refuse to treat me if I refuse to sign this authorization.
- I understand that this authorization may be revoked in writing and delivered to _____at any time, although the revocation will not be effective to previously released protected health information pursuant to a valid authorization.
- I understand that if I authorize disclosure of protected health information, the recipient may further disclose this information, and may no longer be protected by federal rules.
- I understand that North Country Hospital shall have the opportunity to obtain compensation in the nature of

_____from _____ as a result of this authorization.
(describe) (third party)

_____
Date

_____
Signature of individual or representative

_____
Authority or relationship of representative
(Attach copy of documentation of authority)

EXPIRATION DATE: This authorization will expire on (no later than one year from today) _____ (If no date is stated, this authorization expires six months from the date it was signed.)
COPY PROVIDED: The patient will be provided a copy of this authorization.
TO THE RECIPIENT OF THIS AUTHORIZATION AND INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal law. This authorization does not permit further disclosure without patient authorization.
AUTHORITY: This form is designed to comply with CFR 45 Sec. 164.508, regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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189 Prouty Drive | Newport, VT 05855 | 802.334.7331

Name:

DOB:

MRN #:

GENERAL CONSENT TO CARE

I am presenting myself as a patient to North Country Hospital and Health Center, Inc., which includes North Country Hospital and its affiliated clinics (hereinafter "NCH"). I voluntarily consent to such health care as may be validly ordered or recommended by any authorized physician or other medical professional. This care may include laboratory tests, x-rays and other diagnostic procedures and medical treatment. I acknowledge that NCH cannot guarantee the effect of such examination or treatment.

RELEASE OF INFORMATION

I consent to the release from my medical records by my insurance carrier or medical professional responsible for my care of such information as may be necessary. This may include electronic access to my medication history information which may include insurance benefits, eligibility and formulary information, prescribing provider and pharmacy, medication history, as well as prescription refill and renewal information. I also consent to NCH's use and disclosure of such information necessary to carry out treatment, receive payment, or carry out health care operations as described in the NCH Joint Notice of Health Information Practices. I acknowledge receipt of the Joint Notice of Health Information Practices.

TELEMEDICINE HEALTH SERVICE

I further agree and give my consent to participate in a telemedicine health service, including telemedicine services provided by Dartmouth-Hitchcock providers who will be identified to me before services are rendered, if recommended for my care and treatment. During the telemedicine health service, details of my health information, including medical history, examinations, and diagnostic tests, will be discussed with other health professionals using interactive video, audio, and telecommunications technology. Such technology is subject to the following security measures: encryption and HIPAA compliance. Non-medical technical personnel may be present in the area where telemedicine is being performed. I understand there are limitations to the technology and the process of telemedicine, including the potential for incomplete exchange or loss of information, interruptions, and technical difficulties. I understand that the medical records of my telemedicine health services provided by Dartmouth-Hitchcock providers will be maintained by NCH but may also be stored in the Dartmouth-Hitchcock electronic medical record. If I need copies of these records, I should follow NCH's 'Notice of Privacy Practices' to request copies of the records from NCH."

PATIENT RIGHTS

I understand that NCH, and its physician owned practices Notice of Privacy Practices provides information about how they may use and disclose my protected health information. I understand that, in addition to the copy NCH will provide me, copies of the current notice are available by accessing their website at www.northcountryhospital.org.

PERSONAL BELONGINGS

I understand that NCH is not responsible for my personal belongings or valuables. Belongings and/or valuables include, but are not limited to clothing, eyeglasses, eye lens, dentures, jewelry, keys, cell phones, cash, and other similar items.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I hereby agree to direct payment and benefits payable from me to NCH to cover outstanding balances. If I have no insurance or coverage is denied, I understand that I am financially responsible to NCH for the payment of my account in full.

TERMS OF PAYMENT

I understand and agree to the following payment terms:

- All accounts are due when and as billed unless prior payment arrangements are made with the business office.
- Should my account be referred for collection, I shall be liable for all costs of collection, including reasonable attorney's fees and/or collection expenses.

AUTHORIZATION FOR THE USE OF PHOTOGRAPHS

I hereby authorize NCH staff to make and use any images of wounds or other relevant images, to be included in my medical record for treatment and educational purposes. This authorization extends to copies of any said images. I understand that my identity will be protected in the use of these images for purposes other than my medical record.

Recording: I understand that NCH uses surveillance cameras in certain public spaces or common areas in the hospital and its physician owned practices, including but not limited to, hallways in the Emergency Department. I also understand that there are occasions when NCH must provide patient care in such areas. I understand that I provide my consent if I am provided care or treatment in such a space. Images captured by surveillance video are for security purposes only and are only temporarily stored.

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FOR MEDICARE PATIENTS ONLY
AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release any information needed to act on this request. I request that payment of authorized benefits be made in my behalf. I assign payment for the unpaid charges of the physician(s) for whom NCH is authorized to bill in connection with its services.
(Authorization must be signed by the patient, or by an authorized person in the case of a minor or when patient is physically or mentally incompetent.)

****

You are entitled to a copy of this agreement at any time. Keep it to protect your legal rights.

_____ Signature of: _____
Patient or Authorized Person Printed Name Patient or Authorized Person

Date_____

If the patient cannot or is unable to sign consent for care, the signature of either the health care agent or legal guardian who is acting on behalf of the patient, or the patient's surrogate who is consenting to the treatment for the patient must be obtained.

- Patient unable to sign this form due to severity of illness at time of treatment.
- No patient/legal representative available to sign at time of treatment
- Notice of Privacy Practices and Acknowledgement mailed to patient
- Verbal consent received and witnessed due to precautions of visiting patient
- Other reason patient did not sign: _____
  _____

This consent is valid for a period of one year from execution unless sooner revoked by patient or authorized patient representative or until treatment is completed.

Interpreter/Translator: (To be signed by the interpreter/translator if the patient required such assistance)

To the best of my knowledge the patient understood what was interpreted/translated and voluntarily signed this form.

_____ Date: _____
Signature of Interpreter/Translator

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Notice of Health Information Practices

January 1, 2008,
revised June 25, 2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have questions you may contact:

North Country Health Systems
189 Prouty Drive
Newport, VT 05855
ATTN: Privacy Officer

Notice of Health Information Practices

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, which we refer to as your health or medical record, is an essential part of the health care we provide for you.

Your health record contains personal health information, the confidentiality of which is protected under both state and federal law, and by the safeguards we have in place to protect and secure it. Understanding how we expect to use and disclose your health information helps you to ensure its accuracy, better understand who, what, when, where, and why your health care providers and others may access your health information, and make more informed decisions when authorizing disclosure to others.

Part or all of your medical record is in an electronic form, not on paper. That information is available to any provider or employee who has access to our electronic record keeping system, following our confidentiality policies.

Electronic Exchange of Your Health Information

In some instances, we may transfer health information about you electronically to other health care providers who are providing you treatment or to the insurance plan providing payment for your treatment. Your health information may also be made available through the Vermont Health Information Exchange ("VHIE"). The VHIE is a health information network operated by VITL, Inc. and your treating health care providers may only access your health information through the VHIE if you have provided specific written consent for their access, unless you are in need of emergency treatment. For information about the VHIE, see *www.vitl.net*.

Your Health Information Rights

Under the Federal Privacy Rules, you generally have the right to:

- Receive notice of the uses and disclosures we expect to make of your health information. You may elect to receive this notice electronically, but you are also entitled to receive a paper copy upon request.
- Request additional restrictions on uses and disclosures of your health information. We are not required to agree to any such request, with the exception of a request to limit disclosures to a health plan if you have paid for the health services provided at the time of service.
- Request that we send you confidential communications by alternative means or at alternative locations.
- Inspect and obtain a copy of your health record.
- Request that your health record be amended.
- Obtain an accounting of disclosures of your health information made without authorization for purposes other than treatment, payment, or health care operations for a time period no longer than six years.
- Receive notification from us following a breach of your health information.

Some of these rights are subject to exceptions and restrictions according to Federal Rules.

We require a request to inspect and copy to be in writing. We reserve the right to restrict requests to normal business hours with an appointment, if necessary. We also reserve the right to use the time allotted by law to comply with your request. Please direct requests to: Director of Health Information Management, 802-334-3265, Email eprice@nchsi.org . If you seek an electronic copy of your electronic health information in a specific electronic form and format that is not readily producible, we will work with you on an alternative form and format.

Our Responsibilities

We are required by the Federal Privacy Rules to:

- Maintain the privacy of your health information,
- Provide you with notice as to our legal duties and privacy practices with respect to health information we collect and maintain about you,
- Abide by the terms of this notice, subject to the following reservation of rights.

We reserve the right to change our health information practices and the terms of this notice, and to make the new provisions effective for all protected health information we maintain, including health information created or received prior to the effective date of any such revised notice. Should our health information practices change, we will post and/or provide a revised notice upon request. We will not use or disclose your health information without your authorization, except as described in this notice.

We May Use and Disclose your Health Information for Treatment, Payment and Health Care Operations

The examples below are given to give you an idea of how information is used.

We will use or disclose your health information for treatment.
For example: Information obtained by a member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In some cases, your information may be reviewed in preparation for care you may need to receive in the future. Information may be disclosed to identified providers who will provide care to you outside of the Hospital.

We will use or disclose your health information for payment.
For example: Employees responsible for our billing process access your information to produce a bill that may be sent to you or your insurance company or health plan. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. Your insurance company may request additional information.

We will use or disclose your health information for health care operations.
Certain uses of health information are necessary for the day-to-day operations of a health care facility. Some physicians and employees not directly involved in your care may see your information as part of their work. For example: medical staff, risk managers, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to improve the quality and effectiveness of the healthcare and service we provide.

Uses and Disclosures That We May Make Unless You Object

Patient List: We maintain a list of current inpatients in the Hospital. If someone inquires about you by name, we will disclose your room number and telephone extension. If you object, preferably in writing, we will not so disclose this information. We also provide a list of religious affiliations available only to clergy. It is, of course, not necessary to indicate such an affiliation.

Family or friends involved in care: Unless you object, preferably in writing, health professionals may, using their best judgment, disclose to a family member, close personal friend, or any other person you identify health information relevant to that person's involvement in your care or payment for that care.

Other Uses and Disclosures

Unless you object, we may contact you to remind you of your appointments, healthcare treatment options or other health services that may be of interest to you (so long as we are not being paid by another organization to do so).

Required Disclosures

The Federal Privacy Rules require us to disclose your personal health information to you at your request, and to the Secretary of Health and Human Services when requested as part of an investigation or compliance review.

Other Disclosures We May Be Required To Make Without Your Authorization

In addition, Federal Privacy Rules permit uses and disclosure of your health information without your authorization including:

- When required by state or federal law. (This includes, but not limited to, required reports to cancer and mammography registries, reports to law enforcement agencies concerning gunshot wounds; reports on illegal alcohol levels tested in the emergency department on a patient involved in a motor vehicle accident.)
- To state and federal public health authorities, including state medical officers, the Food and Drug Administration (FDA), and other agencies charged with preventing or controlling disease.
- To government authorities, including protective service agencies, authorized to receive reports of abuse, neglect, or domestic violence.
- To state and federal government health oversight agencies, such as the U.S. Department of Health and Human Services.
- To the Vermont Board of Medicine.
- When required or court ordered in a judicial or administrative proceeding.
- To law enforcement officials for certain law enforcement purposes, including the reporting of certain types of wounds or injuries, or pursuant to a court order, or for the purpose of identifying or locating a subject, fugitive, material witness, missing person, or victim, provided that the conditions in the rule are met. We will however, make every effort to protect your privacy, if possible.
- To coroners, medical examiners, or funeral directors for purposes of identifying a deceased person or carrying out their duties as required by law.
- To organ procurement organizations for purposes of organ or tissue donation and transplantation, consistent with applicable law.
- For research approved by an Institutional Review Board (IRB) or Privacy Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- When required to avert a serious and imminent threat to health or safety.
- When requested for certain military or national security government functions authorized by law.
- As authorized by law in connection with workers compensation programs.

Uses and Disclosures Specifically Authorized By You

We shall only make other uses and disclosures of your protected health information on the basis of specific written authorization forms signed by you. Specifically, we may not use or disclose your health information for marketing purposes and we may not sell your health information without your written authorization. Additionally, if psychotherapy notes are part of your health information, they may not be disclosed unless you provide written authorization.

You have the right to revoke any such authorization at any time, except to the extent we have already relied on it in making an authorized use or disclosure. If the disclosure is at our request, your authorization is optional, and your treatment will not be affected.

Fundraising

We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. For the same purpose, we may provide your name to our institutionally related foundation. The money raised will be used to expand and improve the services and programs we provide the community. You are free to opt out of fundraising solicitation, and your decision will have no impact on your treatment or payment for services at North Country Hospital

For More Information or to Report a Problem

If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at the address on the front of this brochure or with the Office for Civil Rights, U.S. Department of Health and Human Services, Government Center, J.F. Kennedy Federal Building, Room 1875, Boston, MA, 02203.
Voice: 617-565-1340, Fax: 617-565-3809, TDD: 617-565-1343

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