100 River Street, Springfield, VT 05156
www.northstarfqhc.org
802-886-8900

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

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. • 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.

continued on next page

Your Rights *continued*

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 information on page 1.
- You can 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. 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 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.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically 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.*
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.*

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How else can we use or share your health 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.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing 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.
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
	  • 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.

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.

Effective Date of Notice 10/31/2023

This Notice of Privacy Practices applies to the following organizations.

Springfield Medical Care Systems, Inc. dba North Star Health.

Patient Demographic Information

Last Name:_____ First Name: _____

Preferred Name: _____ Previous Name(s): _____

Marital Status: Married ☐ Single ☐ Divorced ☐ Date of Birth:_____
Legally Separated ☐ Widowed ☐ Life Partner ☐

Social Security #:_____

Mailing Address:_____ Email Address:_____

City, State, Zip:_____ Home ☐ Alternate Phone ☐_____

Cell Phone:_____

Primary Care Provider:_____

Patient's Employer:_____

Employer Address:_____

Employer City, State, Zip:_____

Work Phone:_____Extension:_____

Person Financially Responsible for Bill after Insurance Payment is received (Complete only if Patient is not responsible)

Responsible Party Information: Spouse ☐ Mother ☐ Father ☐ Guardian ☐ Stepmother ☐ Stepfather ☐

Spouse/Parent/Guardian Name:_____ Social Security #:_____

Address, if different:_____ Date of Birth:_____

City, State, Zip:_____ Employer/Work Phone:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

I authorize North Star Health to discuss my medical care and/or billing concerns with the following individuals. HIPAA release. **Okay to discuss care/bills with Emergency Contact**:_____Yes_____No

Additional names for HIPAA/discussion of care below:

Name:_____ DOB:_____ Relationship:_____ Phone:_____

Name:_____ DOB:_____ Relationship:_____ Phone:_____

Name:_____ DOB:_____ Relationship:_____ Phone:_____

We cannot talk with any friend, relative or spouse who calls for you without the above information completed.

We must have permission from a child's parent or guardian before providing medical services when the child is accompanied by someone other than the parent or legal guardian or presents by themselves. If there may be an occasion where your child will be brought in by a relative, sitter, etc., please request a Parental Authorization Form for us to include with your child's records.

Sexual Orientation and Gender Identity Information

Your sexual orientation and gender identity information is confidential and protected by law, just like all of your other health information. If you are under 18 years old, your parent/guardian may have access to this information. Talk to your provider if you have any concerns. Your provider(s) will use this information to better understand and meet your health care needs. In addition, gathering this information from all patients allows health centers to see if there are gaps in care or services across different populations. © 2023 LGBTQIA+ Health Education Center

Which of the following best represents how you think of yourself? Lesbian, gay, or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Don't know ☐ Refuse to Report ☐
Something else, please describe:_____

How do you currently describe yourself? (check all that apply) Male ☐ Female ☐ Gender non-conforming ☐ Transgender Female/Male-to-Female ☐ Transgender Male/Female-to-Male ☐ Refuse to Report ☐
Additional Gender Category/Other, please describe:_____

What sex were you assigned at birth, on your original birth certificate? Male ☐ Female ☐ Refuse to Report ☐ Unknown ☐

What are your preferred Pronouns? He/Him ☐ She/Her ☐ They/Them ☐

Patient Characteristics

Please be advised that North Star Health is a Federally Qualified Health Center (FQHC), and we are required to gather and report anonymously the following information on the population of patients we serve. We also, anonymously, need to obtain income information of our patients; this will allow us to qualify for grants to provide services for our uninsured, underinsured and/or low-income patients.*

Your Preferred Language: English ☐ Spanish ☐ French ☐ Creole ☐ American Sign Language ☐
Other—Please Print_____

Do you need an interpreter or communication assistance? Yes ☐ No ☐

Do you have a Hearing ☐ and/or Vision ☐ impairment that requires assistance for Effective Communication?

Race (please check <u>all</u> that apply): Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Pacific Islander or Native Hawaiian ☐ White ☐ Other Race—Please Print_____
Refuse to Report ☐

Are you Hispanic/Latino? Yes ☐ No ☐ Refuse to Report ☐

Household Size (how many people live in your home): _____ Household Annual Income: $_____

- Each year, North Star receives federal grant money to help us pay for the services we provided to you and your family. When we apply for this grant, we are required to record the income status of the patients who use the health center.
- We recognize and appreciate that income questions are especially sensitive. Please be assured, in order to keep your confidentiality, we do not report individual names or incomes. Only a numeric summary of patient information is reported.
- Please know that you are not required to do this. However, providing us with this information will help us secure the funding needed to maintain quality health care in our communities.

Are you an Agricultural Worker? Yes—Seasonal ☐ Yes—Migrant ☐ No ☐ Refuse to Report ☐

Are you experiencing Homelessness? Or have you experienced homelessness within the last 12 months?

Yes ☐ No ☐ If, yes what is/was your arrangement status: Homeless Shelter ☐ Transitional Housing ☐

Doubling-up ☐ Street ☐ Permanent Supportive Housing ☐ Other ☐ Unknown ☐

Have you ever served in the military? Yes ☐ No ☐

Insurance Information (WE REQUIRE A COPY OF YOUR INSURANCE CARD AND DRIVER'S LICENSE)
We do not participate with all insurance companies. We may be out-of-network with your plan.

You may require a referral from your insurance plan or primary care physician's office to receive treatment from North Star Health. If so, you will need to obtain this. We are not an Emergency Room or Urgent Care Center and cannot bill as such.

Primary Insurance Company

Insurance Name:_____

Policy Number:_____ Group Number:_____

Policyholder's relation to patient (if other than self): Spouse ☐ Mother ☐ Father ☐ Guardian ☐ Stepmother ☐ Stepfather ☐

Policyholder's Name:_____ Policyholder's Phone Number:_____

Policyholder's Address, if different from above: _____

Date of Birth:_____ Social Security #:_____

Worker's Compensation Injury? Yes ☐ No ☐

Employer:_____ Billing Address:_____

Contact name/phone:_____ Date and type of injury:_____

Claim Number: _____

Motor Vehicle Accident? Yes ☐ No ☐

Policy:_____ Billing Address:_____

Contact name/phone:_____ Date and type of injury: _____

Claim Number: _____

I authorize treatment necessary for the care of the above-named patient. I authorize release of all medical records to any and all referred to providers and to my insurance company via insurance claims forms.

I authorize and request that insurance payments be made directly to North Star Health.

Medicare Policyholders: I request that payment of authorized Medicare benefits be made on my behalf to North Star Health for any services furnished to me.

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits payable for related services.

I acknowledge full financial responsibility for services rendered by North Star Health.

I acknowledge that if laboratory specimen(s) are collected, x-rays are taken, or any Durable Medical Equipment (such as crutches or bracing) are provided I will receive separate billings directly from Springfield Hospital, Dartmouth Hitchcock, Rutland Regional Meical Center, Valley Regional Hospital, or OrthoCare.

I acknowledge North Star Health attaches a $50 service fee for missed or late cancellation of appointments.

I acknowledge that I have received or was offered and declined a copy of the North Star Health Notice of Health Information Privacy Practices (HIPAA).

I authorize messages to be left on my voicemail, answering machine or with a family member informing me of any appointment: Yes ☐ No ☐

_____ _____

Signature of Patient/Authorized Individual **Date**

North Star HEALTH

HEALTH HISTORY

Name: _____ Date of Birth: _____

YOUR PAST MEDICAL HISTORY

___Diabetes ___Hypertension ___CVA/Stroke/TIA
___Heart Disease ___High Cholesterol ___Emotional Problems
___Arthritis ___COPD ___Thyroid Disease
___Dementia ___Cancer: _____
___CHF ___Congenital Abnormalities: _____

ADVANCE DIRECTIVES Do you have a Living Will? ___Yes __No

DO YOU HAVE FREQUENT SYMPTOMS OF

___Headaches ___Chest Pain ___Urine Problems
___Joint Pain ___Muscle Pain ___Stomach Problems
___Cough ___Skin Problems ___Shortness of Breath
___Heartburn/GERD ___Other: _____

DO YOU HAVE ANY ALLERGIES **TYPE OF REACTION**

___Medications: _____ _____
_____ _____
_____ _____
___Foods: _____ _____
___Environmental: _____ _____

TOBACCO USE: ___Yes ___No Past Use? _____

SECOND-HAND SMOKE EXPOSURE? ___Yes ___No Where? _____

ALCOHOL USE: ___Yes ___No How Much? _____

Is there a Family History of Alcohol Use? ___Yes ___No

DRUG USE-Prescription/Street ___Yes ___No Explain _____

Is there a Family History of Drug Use? ___Yes ___No

NUTRITION: Fruits __/day Vegetables __/day Meat __/day Dairy __/day Sweets __/day

EXERCISE: _____Minutes per day Type: __Walk __Run __Swim __Ski __Dance __Weightlifting

PRIMARY LANGUAGE: ___English __Spanish __Other: _____

DO YOU HAVE RELIGIOUS/CULTURAL BELIEFS WE SHOULD BE AWARE OF FOR YOUR HEALTH CARE? ___Yes ___No

EDUCATION COMPLETED: ___Grade School __High School __College __Some College

LEARNING BARRIERS: ___Vision ___Hearing ___Reading __Comprehension

SAFETY:

Smoke detectors in your home? __Yes __No
Do you feel safe at home? __Yes __No
Guns in the home? __Yes __No
Are they locked? __Yes __No
Seat belt use? __Yes __No
Sport helmet use? __Yes __No
Water safety issues? __Yes____No
Tripping hazards at home? __Yes __No

IN THE PAST MONTH

1. Have you felt down, depressed, or hopeless? ___Yes __No
   How often? ___Frequently __Occasionally __Rarely
2. Have you felt little interest or pleasure in doing things? ___Yes __No
   How often? ___Frequently __Occasionally __Rarely
3. Do you have trouble taking medications as directed? ___Yes __No
   Why? (Financial, memory, etc.) _____
4. Do you snore or has anyone told you that you snore? ___Yes __No
5. Did you need help from others to perform everyday activities, such as eating, bathing, walking or shopping?
   ___Yes __No If Yes, Caregiver Name, Relation: _____Phone:_____
6. Do you receive Visiting Nurse services ___Yes __No
7. Do you receive other community services? ___Yes __No (Meals on Wheels, rides, etc.)

HEALTH PREVENTION SCREENINGS

Last Tetanus	_____	Last Pneumovax	_____	Last Flu Shot	_____
Last Dental Visit	_____	Last Eye Exam	_____	Last Physical	_____
Last Pap Smear	_____	Last Fasting Labs	_____	Last Bone Density Exam	_____
Last Colonoscopy	_____	Last EKG	_____	Last Mammogram	_____

PAST SURGERIES: ___Yes __No

_____ Date: _____
_____ Date: _____
_____ Date: _____

DO YOU HAVE SPECIALISTS YOU ROUTINELY SEE FOR YOUR HEALTH CARE? ___Yes __No

Specialist Name: _____ Location & Specialty: _____
Specialist Name: _____ Location & Specialty: _____

DO YOU HAVE EQUIPMENT REQUIREMENTS FOR CARE? ___Yes __No

___Oxygen __Walking Aids __Nebulizer __Chairlift ___Skin Care Needs ___Other: _____

FAMILY HISTORY (Please indicate relative):

___Diabetes _____ ___Hypertension _____ ___CVA/Stroke _____
___Heart Disease _____ ___Substance Abuse _____ ___Emotional/Depression _____
___Cancer _____ Type: _____

WHO CURRENTLY LIVES IN YOUR HOUSEHOLD?

Name: _____ Relation: _____
Name: _____ Relation: _____

FEMALE: HAVE YOU HAD

Last Menstrual Period: _____ ___Abnormal Paps
___Pregnancies: _____ ___Menstrual Problems
___Breast Problems ___Urinary Problems

MALE: HAVE YOU HAD

Last PSA: _____ ___Testicular Problems
___Breast Problems ___Erectile Problems
___Urinary problems

ANY PROBLEMS/CONCERNS NOT MENTIONED ABOVE? _____

MEDICATIONS: Prescription and Over the Counter **BRING ALL MEDICATIONS TO YOUR VISIT**

_____ _____
_____ _____
_____ _____

Signature: _____ Date: _____

WE ENCOURAGE YOU TO COME UP WITH A PERSONAL GOAL FOR YOUR HEALTH!

Your goal should be specific and able to be measured. Some examples include:

- "I will walk three times a week for 30 minutes at a time."
- "I will decrease my soda/sweet tea intake to one drink or less a day."
- "I will decrease my smoking by half."

1. MY GOAL IS: I WILL _____

2. HOW CONFIDENT AM I THAT I CAN REACH THIS GOAL (CIRCLE ONE):

0	1	2	3	4	5	6	7	8	9	10
Not at all		**A little**			**Somewhat confident**			**Very sure**		**Totally confident**

3. CHECK AND/OR WRITE IN ANY BARRIERS THAT MIGHT PREVENT YOU FROM MEETING YOUR GOAL:

___None ___Time ___Money ___Transportation ___Childcare ___Self Desire
___Spouse/Family Influence ___Work Hours ___Energy ___Motivation ___Pain
___Other: _____

Please bring this to your visit, so we can help you monitor your progress toward your goal.

MONITOR YOUR GOAL(S)		
DATE	**GOAL #1**	**GOAL #2**
	Example: Took a 15-minute walk	*Example: Cut out one cigarette*

Signature: _____ Date: _____

COMMUNITY HEALTH TEAM
100 River Street
Springfield, VT 05156
www.northstarfqhc.org

Consent for Use and Disclosure of Health Information for Care Coordination

I, _____, date of birth _____
authorize the use and disclosure of my protected health information (defined below) by the North Star Health and other member organizations of the Springfield Community Health Team.

I understand the Springfield Community Health Team is an alliance of healthcare providers, local and state agencies and community support organizations who are committed to improving my wellbeing through the coordination of services.

I understand that protected health information is defined as any individually identifiable information created or received by a health care provider for the purpose of providing me with health care services. I acknowledge that there is certain health information that may need to be disclosed due to mandatory requirements to certain organizations as indicated below with the (*****) symbol, of which I do not have the ability to object for public and personal safety reasons.

I acknowledge and understand that the Springfield Community Health Team and its members will be responsible for working collaboratively in the evaluation and development of strategies for assisting me in creating a healthier lifestyle and improving my quality of life. The supportive needs may be financial, emotional, educational and/or physical in nature. It is for this reason that I give consent for the use and disclosure of my protected health information, in the form of written, oral or electronic communication, solely between member organizations of the Community Health Team. I also understand that all uses or disclosures of information will meet minimum necessary requirements and will be kept confidential according to standards dictated by the Health Insurance Portability and Accountability Act (HIPAA).

The following is a list of Community Health Team member organizations. If you agree to let North Star Health share your health information with any of the following organizations, please check the box and initial.

Member Organizations	Initial Here
☐ Health Care and Rehabilitation Services (HCRS)	_____
☐ Vermont Department of Health*****	_____
☐ Visiting Nurse & Hospice of New Hampshire & Vermont	_____
☐ Springfield Family Center	_____
☐ Vermont Department of Health Access	_____
☐ Senior Solutions	_____
☐ Vermont Vocational Rehab	_____
☐ Windham and Windsor Housing Authority	_____
☐ Parks Place	_____
☐ Edgar May Health & Recreation Center	_____
☐ Southeastern Vermont Community Action (SEVCA)	_____
☐ Vermont Agency of Human Services*****	_____
☐ Valley Health Connections	_____
☐ Children's Integrated Services	_____
☐ Neighborhood Connections	_____

☐ Home Healthcare, Hospice and Community Services _____
☐ Pathways _____
☐ ServiceLink _____
☐ New Hampshire Department of Health & Human Services* _____
☐ Turning Point _____
☐ Springfield Supported Housing Program _____
☐ Other:_____ _____

I authorize the following information to be shared with staff of the approved Community Health Team member organizations (as listed on page 1):

☐ Yes ☐ No Demographic information (Name, Date of Birth, Address, and other identifiers

☐ Yes ☐ No Health assessments or evaluations
☐ Yes ☐ No History and attendance in alcohol/drug treatment and mental health services (if

☐ Yes ☐ No Mental health and/or drug/alcohol assessment, diagnosis, treatment, progress and

_____ _____
Patient or Representative Signature Date

MRN _____

_____
Relationship of Representative to Patient (if applicable)

North Star HEALTH

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Account #: _____

Patient Name: DOB: Phone: Email:

Address:

Street City State Zip

I authorize my requested healthcare information to be released FROM: (i.e. who has the records now?)

Facility/Organization/Company/Person Phone Fax

Address City State Zip

I authorize my requested healthcare information to be released TO: (i.e. who should the requested records be sent to?)

North Star Health - Health Information Management 802-692-7177 833-405-1938 records@northstarfqhc.org

Facility/Organization/Company/Person Phone Fax Email

100 River Street Springfield VT 05156

Address City State Zip

The Purpose for this Request is: ☐ Transfer Care ☐ Personal Use* ☐ School ☐ Attorney/Legal ☐ Disability ☐ Employment ☐ Insurance

☐ Worker's Compensation ☐ Other _____

***If Personal Use, Preferred Delivery Method:** ☐ In-person Pick-up (photo ID required) ☐ U.S. Mail ☐ Email ☐ Fax

Specific Information to be Released :(subject to copy fees allowed by the state of VT & NH) ☐ Entire Medical Record

☐ Health Record (Date(s) of Service) from: _____ to: _____

☐ Office Notes ☐ Xray Reports ☐ Dental Xrays ☐ EMG/EKG/Tracing/Report

☐ Last Physical Exam ☐ Prenatal/OB Record ☐ Laboratory Results ☐ Other:_____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to North Star Health. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Unless otherwise revoked, **this authorization will expire on (specify date):____/____/_____.** If I have not specified an earlier date, this authorization is valid for one calendar year after the date signed unless canceled in writing. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I may receive a copy of this form.

Information that you authorize to be disclosed may be subject to re-disclosure and no longer protected by law to the extent applicable. I understand that my record may contain information that is considered sensitive under the law. PHI cannot be used or disclosed unless you specifically authorize such use or disclosure under 42-CFR Part 2 of the federal confidentiality regulations. This information shall not be transmitted without specific authorization as provided in these regulations.

My initials below indicate that I permit the following information, if applicable in my health record, to be released:

_____ HIV/AIDS-Related Information, including status, results, treatments, diagnoses and/or referrals

_____ Drug and Alcohol Abuse Information, including status, results, treatments, diagnoses and/or referrals

_____ Behavioral Health Information, including status, results, treatments, diagnoses and/or referrals

_____ Communicable Diseases, including status, results, treatments, diagnoses and/or referrals

_____ _____ _____ _____

Signature of Patient or Legal Representative Date Signature of Witness (if signed by legal representative) Date

Mail completed form to: North Star Health, Patient Business Services, PO Box 710, Springfield, VT 05156

Email completed form to: records@northstarfqhc.org

OFFICE USE ONLY: ID Verified: ☐ Yes ☐ No Date Released: _____ Fee Collected: ☐ Yes ☐ No Amount: _____ Staff Initials: _____

North Star HEALTH

Office Policies and Protocols

Thank you for the confidence you have shown by choosing our office to provide primary care for you and your family. We make every effort to give you the best possible care. To achieve this, please be aware of the following:

APPOINTMENTS

Appointments are required to address any issues or concerns. We reserve appointment times for same day visits daily. We work hard to accommodate requests for same day appointments but may not always be able to schedule you with your preferred provider. If you are late arriving for your appointment by more than 10 minutes, we will make every effort to serve your needs as time allows. However, we will honor scheduled appointments first, and may ask you to reschedule your appointment. We recognize your time is as important as ours and we do our best to remain on time, however medical emergencies do occur, and we may not always be ready to see you at your scheduled time.

WALK INS

Our offices allow appointment access by walk-in for an illness or injury, and/or when a same-day appointment is not available with your primary care provider. Patients frequently seek the services of a hospital emergency department for ailments or injuries that could be treated more economically, and just as effectively, at our office. However, it is not always easy to determine where you should choose to go. Unless it is an emergency, it is best to first seek the advice and services of your own primary care provider.

NO SHOW

If you are unable to keep your scheduled appointment, please call our office in advance to cancel therefore allowing the appointment time to be made available to other patients in need. There is a $50 charge for a no-show appointment, *defined as no notification to the office at least four hours in advance of the appointment time.* The no show charge is your responsibility and is not covered by insurance. If routine no shows occur, *defined as three or more no shows in a 12-month period*, we reserve the right to place you on “same day status” and not allow you to schedule routine appointments in advance. You will be allowed to contact our office on the day of your healthcare need, should we have the availability to see you – you will be scheduled for an appointment.

TEST RESULTS

Typically, our practitioners will recommend a follow up appointment to review lab or test results directly with you. Occasionally they will inform you via mail, phone, or the patient portal. If you have not heard from our office within 15 days, please contact the office.

PHONE CONSULTS-TRIAGE

Nurses are available within our practices to help answer medical questions and/or concerns. Calls to our practice will be taken by a team member who will ask several questions to obtain detailed information about the reason for your call to determine appropriate routing and urgency. These calls are triaged and called back by priority. Our nurses are the front-line link to your provider; they will relay your concerns to your PCP and provide you with appropriate direction.

MEDICATION REFILLS

Please do not allow yourself to run out of medication. You may request a refill up to 5 business days prior to the medication being due for refill by calling your pharmacy, via the patient portal or by calling our office. Controlled medications must be requested through our office or portal. All refill prescription requests will be reviewed within 48 business hours. Your provider requires advance notice, as they need to evaluate your medical records, and address any prior authorization requirements for your medication(s). If there is a delay, you will be notified within 48 business hours of the request. Routine visits with your PCP are necessary to maintain your medication needs.

MEDICAL RECORDS

To provide safe and effective medical care we need to have comprehensive patient information within your medical record. Please notify us of any changes in medication, visits to specialists, recent hospitalizations, emergency care received or changes in your health status. All North Star Health practices have access to your medical records.

A signed medical records release is required should you wish to transfer to an outside facility, or you request documents from within your own chart. Health Information Management (HIM) handles the release of information requests. The contact number for HIM is 802-886-8950.

INSURANCE BILLING

North Star Health accepts most forms of private insurance, as well as Medicare and Medicaid, however, we may not participate with them. This means your claim may be processed as out of network at a higher patient financial responsibility. It is the patient's responsibility to understand their healthcare network and/or insurance plan benefits. Please bring your insurance card to each visit, so that we may ensure we have the correct information.

Please be aware that North Star Health walk-in clinics are not considered urgent care facilities and encounters are billed as primary care office visits.

It is the policy of North Star Health to submit claims to third-party payers in a timely manner as a courtesy to patients and to receive prompt payment for services rendered. We will bill your insurance company; however, you are responsible for any outstanding balances not covered by your plan. If you are deemed ineligible for Medicaid at the time of service, or the services provided are not covered by Medicaid you will be asked to acknowledge financial responsibility through signing a waiver.

Co-payments are your responsibility as a patient. Payment is due at the time of service. It is considered a contractual requirement between you and your insurance and our organization. We can accept cash, check, credit, or debit card for your convenience.

If checks are returned for non-payment, you will be charged a $30 fee for related expenses.

Should you have questions regarding your billing statement, please contact our billing office at 802-886-8950.

FINANCIAL ASSISTANCE

North Star Health provides access to a comprehensive range of health care services, with financial assistance offered based on a sliding fee scale. The amount of financial assistance available is determined based on annual income and family size, according to the most recent Federal poverty guidelines. To help improve access to care, enrollment assistance is also offered through our partner, Valley Health Connections, for public insurance programs including State Medicaid programs, children's programs, and referral assistance is offered for Medicare insurance programs. They also offer eligibility assistance for prescription pharmacy programs. If you would like more information about these programs, please call Valley Health Connections at 802-885-1616 for more details or to set up a personal consultation.

AFTER-HOURS CARE

If you have a true medical emergency, please call 911 or go to the nearest emergency room to receive medical treatment immediately. For all non-emergencies please contact our office number after hours to speak with the answering service; they will connect you with either the nurse triage service or the practitioner on call. Prescription refills are not available after hours. Please contact the office during normal business hours.

REFERRALS

Most referrals require an office visit. When your provider determines you need to be referred to a specialist, it could take up to 7- 10 business days for completion. If it is an urgent referral, it will be completed within 48 hours. Some referrals require prior authorization from your insurance company which can take additional time to process. Please inform the office if you decide to cancel the specialist or testing completely so that we can notate your record. We will provide appropriate medical records for the specialist for your visit.

SELF REFERRALS

Your insurance *may require* a formal referral to obtain care outside of your Primary Care Provider (PCP) location, please inquire with them directly. To ensure we receive documentation of outside care, please inform them of your PCP name and address so that they will send any documentation to be included in your medical chart.

CONTROLLED SUBSTANCES

We are mandated to follow strict rules when prescribing controlled substances such as narcotic pain medication, or benzodiazepines. Please be aware our office does not prescribe these medications lightly. For chronic use of controlled substances, routine appointments will be required to evaluate your symptoms and establish a Controlled Substance Agreement, which provides additional stipulations and expectations for these medications to be maintained. All prescriptions provided are your responsibility to keep secure; any lost or stolen medications will not be replaced. You may be asked to bring your medication to the office and/or urine toxicology may be required.

North Star HEALTH

Patient Portal Terms of Use

In our on-going commitment to improve services, North Star Health offers secure online access to some of your medical records and the ability to communicate with your provider and care team for patients 18 years and over and for the guarantor/guardian of a child between the ages of 0-11 years of age. Patients 12 to 17 years may have access to their own records via the portal, the guarantor/guardian will have billing only access. Secure messaging can be a helpful tool but has certain risks. By checking the box, you accept the risks and agree to follow the Terms of Use as described below.

I. Terms of Use – General Policies and Procedures

The Patient Portal has the Following Functions (Please see North Star Health's participation invitation for functions currently offered):

- Send and receive e-mail and secure messaging for non-urgent needs.
- View lab, vitals, and radiology results that have been sent to you.
- View and print a summary of your last clinic visit.
- Schedule, reschedule and cancel appointments.
- View and print letters from your provider or clinic • View and submit updates to your health information.
- View selected health information (allergies, vaccinations, procedures, medications, past medical history). **Note - You can submit changes/additions to your health records, medication lists, etc., but this will not change your permanent record without our review of the information.*
- Update your demographic information (i.e., address, phone numbers).
- Receive patient reminders for routine health maintenance.
- Make payments, review payment history, review statements, add/update payment methods.

Use the Portal to send Secure Messages:

- For non-urgent medical questions, lab results, routine follow-up questions, etc.
- **Reasonable efforts will be made to respond to portal inquiries within one (1) business day, but no later than three (3) business days, after receipt.** Response time may be longer if the Patient Portal service is interrupted for maintenance, upgrades, or emergency repairs related to events beyond our control. In this respect, you agree not to hold North Star Health, its providers, or any of its staff, in any way liable or responsible to you for any such modification, suspension, or disruption of the Patient Portal.
- You are encouraged to use the Patient Portal at any time; however, messages submitted after-hours, weekends and holidays are held until we return the next business day.
- North Star health reserves the right to suspend or terminate user access at our discretion, at any time and for reasons that may include but are not limited to: patients not seen by their medical provider in the preceding 12 months or who have transferred their care elsewhere; portal non-use; or inappropriate, abusive, or negligent portal use.

DO NOT use the Patient Portal to ask about (i) an emergency, (ii) an urgent issue, (iii) patient complaints/grievances.

Communications Will Become a Part of Medical Record:

- Messages sent via the Patient Portal will be included in your permanent medical record.

Changes to these Terms of Use:

- Terms of Use may be modified from time to time.
- If material modifications to the Terms of Use are made, information will be posted in the Patient Portal notifying you that a material change has been made.
- If you then continue to use the Patient Portal, you will be deemed to have agreed to follow the modified Terms of Use.
- If you do not agree with the modified Terms of Use, then you must notify us that you no longer wish to use the Patient Portal.

Medical Advice and Information Disclaimer:

The Patient Portal may include general information or education that should not be construed as specific medical advice or instruction. Nothing in the Patient Portal is intended to be used for medical diagnosis or treatment and should not be considered complete or relied on to suggest a course of treatment for a particular individual. You should always seek the advice of your physician with any questions you may have regarding a medical condition, and you should never disregard medical advice or delay in seeking it because of general information or education you may find on the Patient Portal.

When North Star Health posts information provided by a third party, North Star Health will make reasonable efforts to credit the source. North Star Health does not warrant, either expressly or by implication, the factual accuracy of the information posted, but believes all statements made to be reliable and accurate based upon representations made by the authors themselves. North Star Health accepts no fault or liability for any error or omission with respect to such statements.

II. Terms of Use – Privacy and Security

Privacy:

- All messages sent to you in the Patient Portal will be encrypted.
- E-mails from you to any staff member should be sent through the Patient Portal or they are not secure.
- All e-mail address lists will be kept confidential and such lists will not be shared with other parties, unless necessary to carry out Patient Portal operations (e.g., perform system upgrades to the Portal) or required by law.
- A variety of healthcare and administrative personnel (such as nurse practitioners, physician assistants, registered nurses, certified medical assistants, clerks, etc.) will be involved in reading, processing, and replying to your messages and information submitted through the Patient Portal. (Similar to how phone communication is handled). Staff members other than your primary care provider will be involved in receiving your messages and routing them to your provider, a nurse, or the front desk, as necessary.
- There is no need to notify us that you have read a message unless you have a question or need further information.
- Read our Notice of Privacy Practices for information on how private health information is handled in our organization.
- If you have concerns, please ask to speak with the Clinic Director or the privacy officer.

How Secure Patient Portal Works:

The Patient Portal is a webpage that uses encryption and other security measures designed to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information are designed to be read only by someone who knows the right password or passphrase to log in to the Patient Portal site.

How to Participate in our Patient Portal:

You will be provided with a web URL link via email, or the link is available on our website northstarfqhc.org. You will click sign-up today which will take you to the page to create an account. You will be asked to confirm your Legal first and last name, date of birth, legal sex, email, and phone number which must match your North Star Health records. You will be required to set your password. Please choose something secure and do not share that password with anyone else. This is essential to make sure your information remains secure and private! The final option presented will be to choose Secret Questions from the dropdown choices. After completing these steps, you will have access to the portal site.

Protecting Your Private Health Information and Risks:

This method of communication and viewing information through the Patient Portal is designed to prevent unauthorized parties from being able to access or read messages during transmission by using industry standard secure Socket Layer (SSL) encryption to ensure secure data transmission as well as server-side digital certificate authentication. To prohibit unauthorized access, all medical information is stored in an electronic record system behind our electronic health record vendor's firewall. Other security measures protect information maintained within the Patient Portal site.

Keeping messages secure depends on two additional factors: a) the secure message must reach the correct e-mail address, and b) only the authorized individual must be able to get access to it. Only you can make sure these two factors are present. Please make sure that we have your correct e-mail address and are informed if it ever changes. You also need to keep track of who has access to your Patient Portal account, so that only you or someone you have authorized can see messages or other information in your Patient Portal. You should protect your Patient Portal log-in information from anyone whom you do not want to access your Patient Portal account and notify us immediately of any unauthorized use of your log-in information or you believe your log-in is no longer confidential.

We will not answer questions or send protected health information by regular e-mail. All health-related e-mail communication will be done through the secure and encrypted Patient Portal site.

Even with these security measures, we cannot guarantee the confidentiality, security or integrity of Patient Portal information. To the fullest extent allowed by law, you agree not to hold North Star Health, its providers or any of its staff liable for network infractions beyond its control.

Vermont Patient Bill of Rights and Responsibilities

As a Federally Qualified Health Center, North Star Health strives to provide affordable, accessible, high quality, patient-centered healthcare services to individuals and families. To that end, patients of any North Star Health practice can expect to be treated with respect and dignity and encounter staff and providers who genuinely care for your health and wellbeing.

In order to provide you with exceptional care, both you and North Star Health have rules we need to follow. These rules govern the conduct and responsibilities of our health center employees and patients. These rules are defined as the "Patient Bill of Rights and Responsibilities."

YOU HAVE THE RIGHT TO:

- Receive service(s) without regard to age, race, color, sexual orientation, marital status, religion, sex, national origin, or other personal characteristics including source of payment for your care;
- Be treated with consideration, respect and dignity including privacy in treatment;
- Be informed of the services available at the health center;
- Be informed of the provisions for off-hour emergency coverage;
- An interpreter and translation services, assistive devices, and communication aids and services, at no cost to you.
- Be informed of and receive an estimate of the charges for services, view a list of the health plans and hospitals that the center participates with; eligibility for third-party reimbursement and, when applicable, the availability of free or reduced cost care;
- Receive an itemized copy of his/her/their/their account statement, upon request;
- Obtain from his/her/their health care practitioner, or the health care practitioner's delegate, complete and current information concerning his/her/their/their diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand;
- Receive from their clinician information necessary to give informed consent prior to the start of any nonemergency procedure or treatment or both. An informed consent shall include, as a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision;
- Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her/their action;
- Refuse to participate in experimental research;
- Voice grievances and recommend changes in policies and services to the center's staff, the operator, and the Vermont State Department of Health without fear of reprisal;
- Express complaints about the care and services provided and to have the center investigate such complaints. The center is responsible for providing the patient or his/her/their designee with a written response within 30 days if requested by the patient indicating the findings of the investigation. The center is also responsible for notifying the patient or his/her/their designee that if the patient is not satisfied by the center response, the patient may complain to the appropriate external agency;
- Privacy and confidentiality of all information and records pertaining to the patient's treatment;
- Approve or refuse the release or disclosure of the contents of his/her/their/their medical record to any health-care practitioner and/or healthcare facility except as required by law or third-party payment contract;
- Access to and receive an accounting of disclosures regarding your own health information as permitted under applicable law.

To provide safe and comprehensive services, North Star Health asks its patients to adhere to the following responsibilities:

HEALTH CENTER RULES AND REGULATIONS

- Inform the Health Center personnel of any changes in your treatment or condition.
- Supply accurate and complete information whenever possible to your provider regarding all factors and changes affecting your health status.
- Cooperate with those providing care.
- Avoid discrimination in any form against Health Center personnel and other patients and visitors.
- Ask questions if you do not fully understand your care.
- Inform the Health Center staff if you need to cancel a scheduled visit, preferably 24 hours prior to the visit.
- Provide the Health Center with the name, address, and phone number of the person to contact in case of emergency.
- Inform the Health Center of any changes affecting your financial status and/or need for service.
- Arrive at the Health Center in advance of your appointment, as directed, so all necessary papers can be completed with the patient or designee prior to the visit with the provider.
- Understand that arriving considerably late for an appointment means the provider may not be able to see you. It will be considered a missed appointment, and it may be rescheduled.
- Observe all rules and regulations of the health Center, particularly those relating to safety. The health Center has an obligation to make this information known to you.

RESPECT AND CONSIDERATION

- Be considerate of the rights and privacy of staff and other patients by helping control noise and refraining from recording devices in the health center.
- Be courteous to staff & other patients and refrain from being verbally or physically abusive. Threatening statements or behavior towards staff or other patients may result in you no longer receiving services from North Star Health.
- Not bring weapons within the boundaries of the health center property
- Follow the No Smoking policy.
- Be respectful of the property of other people and of North Star Health.

COMPLIANCE WITH INSTRUCTIONS

- Follow the mutually agreed upon prescribed course of treatment. This may include following the nurse's or other personnel's instructions as they carry out your coordinated plan of care.
- Understand and accept the risks associated with refusing treatment or not following provider instructions. This includes failure to follow through on recommended screenings, referrals, orders, and tests.

PROVISION OF INFORMATION

- Communicate, to the best of your knowledge, an accurate and complete medical history to the providers and others providing health care services.
- Report any changes in your condition promptly to the provider, nurses and others providing health care services.
- Make it known whether you clearly understand explanations or instructions given and for stating your inability to follow completely any instruction given.

PAYMENT OF SERVICES

- Provide all necessary information including insurance card and policy number to assure timely processing of your bill and to make appropriate arrangements for the payment of your bills. You are also responsible for understanding the limitations of your insurance coverage and you must present any co-pay or other personal obligations at the time service is rendered.

Please note that patients who behave in a disruptive manner so as to threaten their own or another's safety, or who are verbally and/or physically threatening or abusive will be asked to leave the premises. In these cases, patients will be subject to the actions and decisions of the North Star Health Executive Leadership Team. These decisions and actions may include notification to law enforcement or other legal authorities, and/or discharge from North Star Health practices and/or denial of future non-emergency care.