

Patient Registration

Patient Information

Last Name _____ First Name _____ MI _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home # _____ Cell # _____ Work # _____

Birth Date _____ SS# _____ - _____ - _____

Sex: Male Female

Marital Status: Single Married / Civil Union Partnered Widowed

Emergency Contact _____

Phone # _____ Relationship _____

Person Responsible for this Bill / Guarantor

Last Name _____ First Name _____ MI _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home # _____ Cell # _____ Work # _____

Relationship to Patient: Self Spouse Partner
 Parent Other _____

Authorization

"I certify that the above information is true and correct and I will notify Thomas Chittenden Health Center, PLC of any changes in my living status."

Print Name _____

Signature _____ Date _____

Insurance Information

Primary Insurance

Policy Holder _____ Sex: Male Female

Birth Date _____ SS# _____ - _____ - _____

Relationship to Patient: Self Spouse / Partner Parent

Name of Company _____

ID # _____

Group # _____ Member # _____

Secondary Insurance

Policy Holder _____ Sex: Male Female

Birth Date _____ SS# _____ - _____ - _____

Relationship to Patient: Self Spouse / Partner Parent

Name of Company _____

ID # _____

Group # _____ Member # _____

Please show your insurance card to the receptionist.

Authorization

"I certify that the above information is true and correct and I will notify Thomas Chittenden Health Center, PLC of any changes in my insurance status. I authorize the release of medical information necessary to process my claims."

Print Name _____

Signature _____ Date _____

Consent Form

Consent to Use or Disclose Protected Health Information for Treatment, Payment and Health Care Options

I consent to allow Thomas Chittenden Health Center, PLC to use or disclose my protected health information for treatment, payment and health care options.

1. **Treatment** means the provision, coordination, or management of health care and related services by one or more health care providers.
2. **Payment** means the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provisions of health care.
3. **Health care operations** means conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; underwriting, premium rating, and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of Thomas Chittenden Health Center, PLC.

Please initial below to indicate your consent.

___ I consent to the disclosure of my prescription medical information by any provider, mental health provider, pharmacy, insurer or prescription benefits manager, specifically including any state or federal health benefits program to Thomas Chittenden Health Center, PLC for the purpose of my treatment.

I consent to allow Thomas Chittenden Health Center, PLC to disclose my protected health information for treatment activities of another health care provider.

I consent to allow Thomas Chittenden Health Center, PLC to disclose my protected health information to another covered entity or to another health care provider for the payment activities of the entity that receives the information.

I consent to allow Thomas Chittenden Health Center, PLC to disclose my protected health information to another covered entity for health care operations activities, provided that Thomas Chittenden Health Center, PLC and the other covered entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment, or health care operations or for the purpose of health care fraud and abuse detection or compliance.

I acknowledge that this consent may be revoked by me at any time, except to the extent that Thomas Chittenden Health Center, PLC has already acted in reliance on it.

Name of Patient _____

Relationship to Patient _____

Signature _____ Date _____

Due to recent changes in Federal regulations we are required to collect following information for all Thomas Chittenden Health Center patients.

Patient Name: _____

Date: _____

DOB: _____

MRN: _____ (For Office Use Only)

Demographic questions

Race

- Asian American Indian or Alaska Native Black, African American
 Native Hawaiian Pacific Islander White More than one race
 Refused to report

Are you of Hispanic or Latino origin? Yes No

Preferred Language: _____

Thank you for your cooperation in collection this valuable data

Receipt of Privacy Notice and Billing Policies

____ I acknowledge that I have received a copy of Thomas Chittenden Health Center's **Notice of Privacy Practices**.

____ I acknowledge that I have received a copy of Thomas Chittenden Health Center's **Billing Policy Agreement**.

Any questions I have regarding either of these policies have been answered to my satisfaction.

Signature _____

Date _____

To Our Patients:

The physicians at Thomas Chittenden Health Center are committed to providing patients with the best possible medical care. This payment policy was established to clearly outline patient financial responsibilities and to avoid any misunderstanding or disagreement concerning payment for professional services rendered at Thomas Chittenden Health Center. If you have any questions after reading our payment policy, please call our billing office for additional information. We are here to help you.

Respectfully,
The Physicians

PAYMENT POLICY

In order for Thomas Chittenden Health Center to successfully bill for the medical services rendered to you, we must rely on you to provide us with complete and accurate information. In order to assist us, for every appointment, please arrive 5 minutes early and be prepared to:

- Confirm/update your current address, telephone number and payment information;
- Make payment for the amount due at time of service according to this payment policy;
- If you have medical insurance, notify the receptionist of any insurance changes, provide all of your current insurance card(s) and properly identify each insurance plan as primary, secondary or tertiary;
- Inform us if your visit is for an injury that should be covered by workman's compensation or accident insurance.

Payment due at time of service:

All patients are expected to make payment for their portion of the bill on the day services are rendered or contact our billing office staff to make financial arrangements. Payment may be made by cash, check, credit card or debit card.

- If you **do not have medical insurance** you are expected to pay in full on the day services are rendered. A 30% discount will be applied if you have no insurance and pay at the time of service. If you do not pay at the time of service a payment plan must be arranged at the time of service.
- If you have medical insurance coverage by a plan with which **we have a contract** you are expected to pay your co-pay on the day services are rendered. If you **do not pay** your co-pay at the time of service and we have to send you a bill, an additional \$10.00 fee will be added to your account to cover our costs.
- If you have medical insurance coverage by a plan with which **we do not have a contract** you are expected to pay in full on the day services are rendered.

Thomas Chittenden Health Center currently has **contracts with the following insurance plans:**

Aetna (w/First Health Logo)	Aetna Open Access Select	Aetna PPO	Aetna POS2
BCBS of Vermont	Beechstreet Network	CBA/EBPA	Cigna
Coventry/First Health Network	Fletcher Allen Health Care	Great West Network	Medicare
MVP	Tricare for Life	United Healthcare	VT Managed Care
Vermont Medicaid/Primary Care Plus	* (<u>NOT Aetna HMO or Aetna Tricare</u>)		

Outstanding balances:

Patients are expected to pay for services rendered according to this payment policy or contact our billing office staff to make financial arrangements. If we do not receive payment of your statement balance or a phone call to set up a payment plan within 30 days, your account will be considered past due and our staff will proceed with collection efforts. Please review your statement carefully and contact our billing office immediately if you have questions or think that you received the statement in error. **If your account is past due, please contact our billing office staff to discuss your account and make financial arrangements. We are here to help you.**

Insurance claims:

We will submit your insurance claims for you if you provide us with complete and accurate information. In order for us to successfully submit your claims you must:

- Notify us immediately of all insurance changes;
- Present all of your current insurance cards **at every appointment**;
- Properly identify each insurance plan as primary, secondary or tertiary.

If you have an insurance plan with which **we do not have a contract**, you are expected to pay in full on the day services are rendered. We will submit your insurance claims for you as a courtesy however you are ultimately responsible for payment for services rendered. If you and your insurance plan both pay for your services, we will refund your payment by check.

If you have an insurance plan with which **we have a contract** and payment is not received from your insurance company within 45 days of the billing date, payment of the remaining balance will be your responsibility. When necessary, we may ask you to assist us in working with your insurance company to obtain payment for services.

Non-covered services:

Your insurance plan may not cover all medical services and may determine some services to be "not medically necessary". When your insurance plan makes this determination and allows us to bill you, you will be responsible for payment for the non-covered services.

Knowing your insurance benefits coverage is your responsibility. Please read your insurance plan materials carefully and contact your insurance company with questions so you are not surprised.

Coordination of benefits:

If your insurance company denies your claim(s) due to coordination of benefits, you will be responsible for payment of the remaining balance for services rendered. **If you receive a statement from Thomas Chittenden Health Center stating a Coordination of Benefits issue you must call your insurance company immediately to straighten out your account with them and ask them to re-process your claim.**

Workman's compensation or accidents:

If your visit is for an injury and should be covered by workman's compensation or accident insurance you must inform our staff when you schedule your appointment and complete the required forms when you check-in. If you do not provide us with all of the necessary information you will be responsible for payment for services rendered.

Custodial parent:

By law, if you are a custodial parent, you are responsible for your child's medical bills, even if you are not the carrier of your child's insurance policy.

Missed appointments:

We reserve the right to charge you for a missed appointment. If you are unable to attend a scheduled appointment you must call in advance to cancel. Insurance does not pay for missed appointments.

Lab services:

While we perform many laboratory services here at Thomas Chittenden Health Center, some tests ordered by our providers are performed at outside laboratories such as Fletcher Allen Health Care. You or your insurance company will receive a separate bill from an outside laboratory for those services.

NOTICE OF PRIVACY PRACTICES

Notice of Health Information Practices

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.

Understanding Your Health 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. It serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you receive
- Means by which you or a third-party payer can verify that services billed were actually provided
- Tool for educating health professionals
- Source of data for medical research
- Source of information for public health officials charged with improving the health of the nation
- Source of data for facility planning and marketing
- Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Your health record contains personal health information, the confidentiality of which is protected under both state and federal law. Understanding we expect to use and disclose your health information helps 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

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. Under the Federal Privacy Rules, 45 CFR Part 164, you have the right to:

- Receive notice of the uses and disclosures we expect to make of your health information, including a paper copy of the notice if requested, as provided in Rule 520.
- Request additional restrictions on uses and disclosures of your health information (though we are not required to agree to any such request), or request that we send you confidential communications by alternative means or at alternative locations, as provided in 45 CFR 164.522.
- Inspect and obtain a copy of your health record as provided in 45 CFR 164.526.
- Obtain an accounting of disclosures of your health information made after April 14, 2003, for purposes other than treatment, payment or health care operations, as provided in 45 CFR 164.528.
- Please direct requests to:

Thomas Chittenden Health Center, PLC
586 Oak Hill Road
Williston, Vermont 05495
Telephone: (802) 878-8131
Fax: (802) 879-6853.

Our Responsibilities

We are required by the Federal Privacy Rules to:

- Maintain the privacy of your health information
- Provide you with a 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. We will not use or disclose your health information without your consent or authorization, except as described in this notice.

Uses and Disclosures for Treatment, Payment, and Health Operations, Based on Your Consent

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of **Thomas Chittenden Health Center, PLC** will be recorded in your medical 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 that way, the physician will know how you are responding to treatment.

We will also provide your primary care physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you. We may also send relevant portions of your medical record to specialists to whom you are being referred for care, or to physicians whom your providers here may want to consult on a care issue.

We may use and disclose health information about you (for example, by calling you or sending you a letter or card) to remind you that you have an appointment with us for treatment or that it's time for you to schedule a regular

Uses and Disclosures for Treatment, Payment, and Health Operations, Based on Your Consent,
continued

checkup with us, or to provide you with information about treatment alternatives.

We will use your health information for payment

For example: A bill 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.

We will use your health information for regular health operations

For example: Members of the Thomas Chittenden Health Center, PLC or members of a 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 continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates

We provide some services with business associates, who are independent professionals that use patient health information provided by us in order to perform these services. Examples include a billing service and an answering service. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your insurer for services rendered. To protect your health information, we require the business associate to appropriately safeguard your information.

Uses and Disclosures that We May Make Unless You Object

Family or friends involved in care:

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

Marketing and fundraising:

We may use or disclose your health information in connection with limited marketing or fundraising communications permitted under the Federal Privacy Rules. Any such communication addressed to you will contain instructions describing how you may "opt out" of receiving further such communications.

Required Disclosures

The Federal Privacy Rules requires us to disclose your personal health information in two instances:

- To you at your request under 45 CFR 164.524 or 45 CFR 164.528 and
- To the Secretary of Health and Human Services when requested as part of an investigation or compliance review under 45 CFR 164.502.

Disclosures Permitted Without Consent for National Priority Purposes

In addition, 45 CFR 164.512 permits uses and disclosure of your health information without your consent or authorization for certain "national priority" purposes, including:

- When required by state or federal law
- 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 government health oversight agencies, such as the state and federal Departments of Health and Human Services, Medicare/Medicaid Peer Review Organizations (PRO's), state Boards of Medicine, Nursing, and Pharmacy, and other licensing authorities.
- When required by court order 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 warrant, subpoena, or other legal process, 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.
- 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 protocol and established protocols to ensure the privacy of your health information.
- When required to avert a serious threat to health or safety.
- When requested for certain specialized government functions authorized by law, including military and similar situations.
- As authorized by law in connection with workers compensation programs.

Uses and Disclosures Specifically Authorized by You

We expect to make other uses and disclosures of your protected health information only on the basis of specific written authorization forms signed by you. 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.

For More Information or To Report a Problem

If you have any questions, you may contact the office of: Thomas Chittenden Health Center, PLC
586 Oak Hill Road
Williston, Vermont 05495
Telephone: (802) 878-8131
Fax: (802) 879-6853.

If you believe your privacy rights have been violated, you can file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services, Government Center, J.F. Kennedy Federal Building - Room 1875, Boston, Massachusetts 02203; Telephone (617) 565-1340; TDD (617) 565-1343; Fax (617) 565-3809; E-mail OCRComplaint@hhs.gov

Effective Date: April 14, 2003

