Gifford Health Care

44 South Main Street, P.O. 2000 • Randolph, Vermont 05060
802-728-7000 • *fax* 802-728-4245
www.giffordhealthcare.org

Welcome to Gifford Health Care!

Gifford Health Care, an FTCA-deemed Federally Qualified Health Center, is a network of community health centers throughout central Vermont and the Upper Valley offering primary care, behavioral health, and dental services. At Gifford, we believe in being a true partner in our patients' health, combining the highest quality care with a genuine, personalized approach. From advanced facilities to family-friendly providers, we are uniquely dedicated to your health… for life.

For your convenience, we have enclosed several forms that we would like you to complete prior to your first appointment. Please bring the completed forms with you to your appointment.

Patient Registration: This form is needed to complete your registration as a new patient at Gifford. It covers basic contact information, insurance details, and other data we are required to collect for each new patient.

Medical and Family History: This form will help our providers understand your past personal medical history as well as those of your family to help them build a better picture of your current healthcare needs.

HIPAA Consent: This form provides us with permission to access your health information for the purposes of providing treatment, payment, or healthcare operations.

Health Information Release: If you previously received care from a health care provider outside of the Gifford network, we ask that you complete this form and submit it to your former health care provider's office so that we can obtain your past medical records to help us build a complete picture of your medical history.

Medications: Your medications are important to us. Please provide us with your current medication list when you arrive for your visit. This should include any over the counter, herbal medication, or vitamins you take. It would be helpful if you brought your pill bottles so we can review them together.

Payment: Co-payments are expected at the time of service. Gifford serves all patients regardless of income or insurance status. We offer services on a sliding fee scale basis, adjusted for family size and income. If you need help with affordable care options or signing up for health insurance, please contact our Health Connections office at (802) 728-2323.

Services: We provide onsite X-ray services at our Berlin, Randolph, and Sharon clinics. Lab services are available at each of our primary care locations by appointment. Walk-in lab services are available at Gifford Medical Center in Randolph.

Office Hours: We offer evening and weekend hours and will do our best to find a time and location that works for you. As a patient of Gifford, you may visit any of our offices for your urgent care needs.

After Hours: The telephones are transferred to voicemail after the last appointment of the day. After that time, the caller is instructed to contact the hospital's main switchboard at (802) 728-7000 to reach the provider on-call.

Compliments/Concerns: Our promise is to provide you and your family with the best care possible in a compassionate environment. If at any time you don't feel like we've delivered on this promise, please talk to your nurse, provider, or ask to speak with the practice manager at the clinic where you are being seen. You can also contact our Patient Relations Specialist (Mon.-Fri. 7:30 a.m.-4:30 p.m. at (802) 728-2433) who can assist patients and families with concerns regarding their care at Gifford. You will also have the opportunity to complete patient satisfaction surveys. We hope you take this chance to tell us how we are doing so we can make improvements for you.

We look forward to meeting you and thank you for entrusting us with your care!

Gifford Health Care

Gifford Health Care Primary Care Practices have been awarded recognition by the National Committee for Quality Assurance **Patient-Centered Medical Home Program**

What is a Patient-Centered Medical Home?

A Patient-Centered Medical Home coordinates your medical care as a healthcare team – putting the focus of your health care on you, where it belongs! It is a partnership between the healthcare team and the patient. The Patient-Centered Medical Home team facilitates a partnership between individual patients, his or her primary care provider, and the patient's family. Medical care is facilitated by evidence-based guidelines through registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need. Patients are assured that medical care will be carried out in a culturally and linguistically appropriate manner.

What are the benefits that you can expect?

Team-Based Care:

Your primary care provider is the team leader. The team will be supported by the medical office staff and support staff to work with you to meet all of your medical needs. We will use information systems tools and medical registries to optimize your medical care.

Health Access and Communications:

For urgent care issues during working hours, your primary care team will see you on the very day that you have an urgent health care need. You will simply need to call the clinic in your area during working hours to schedule a same-day appointment. Many urgent care needs can be handled here in the office. You will then avoid having a prolonged and expensive visit to the emergency room. We also offer appointment times in our Randolph office on Saturdays. If you need healthcare guidance after normal business hours, you can call (802) 728-7000.

Patient-Centered Medical Home

Our Pledge to You:

We listen to your questions and concerns and clearly explain disease/diagnosis, treatment, and results of diagnostic tests.

The care team is responsible for coordinating your care whether with it is with us or if we are referring you to other resources in the community.

Provide clear instructions about your treatment goals and future plans for every visit.

We will provide behavioral health needs through annual depression screening, medical management, and referrals for counseling and psychiatric evaluation as needed.

What We Ask of You:

Ask questions and actively participate in your care.

Provide your complete medical history and other important information including any changes in your health and information about care outside the practice.

Sign a transfer of medical records form to have your previous medical records sent to us.
Let us know if you see another provider so that we may keep a complete record of your care and so that we can help with any coordination you may need.

We provide equal access to all patients regardless of their source of payment or ability to pay. For information about financial assistance options, such as help obtaining insurance and sliding fee discounts, please call Health Connections, our Affordable Care Program, at (802) 728-2323.

Gifford Health Care

Please bring this form with you to your first appointment, along with your medical insurance card(s).

New Patient Registration

Patient Information

Name: First: _____ Middle: _____ Last: _____

Date of Birth: _____ / _____ / _____ SS #: ____ - ____ - _____ Sex: ☐ Male ☐ Female

Please remember that your name, date of birth, SS #, and sex in our system must match your insurance records. Please inform us of any inaccuracies. You may need to contact your insurance company to correct.

Mailing Address: _____

Physical Address (if different): _____

Home Phone: _____ Cell Phone: _____

Email: _____

Marital Status: ☐ Married ☐ Single ☐ Partner/Significant Other ☐ Separated ☐ Divorced ☐ Widowed

Primary Language Spoken: ☐ English ☐ Spanish ☐ French ☐ Other _____

Do you need interpreter/TTY/ASL services? ☐ Yes ☐ No

Race: ☐ White/Caucasian ☐ Black/African-American ☐ Native Hawaiian
☐ Asian ☐ American Indian/Alaskan Native ☐ Other Pacific Islander

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino

Employment Status: ☐ Full-time ☐ Self-employed ☐ Not employed ☐ Military-Active
☐ Part-time ☐ Retired ☐ Disabled ☐ Military-Reserves

Employer Name/Address: _____

Student Status: ☐ Not a student ☐ Part-time student ☐ Full-time student

Emergency Contact: Name: _____ Phone: _____ Relationship to Patient: _____

Additional Information

As a Federally Qualified Health Center, we are required to ask the following questions. We realize some of the questions are very personal. Your response is optional. Any information you provide is kept strictly confidential and can help our providers deliver appropriate services tailored to your needs.

Are you homeless? ☐ No ☐ Yes (if Yes)→ ☐ Homeless shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other

Please check if you are a: ☐ U.S. Veteran ☐ Seasonal Agricultural Worker ☐ Migrant Worker

Sexual Orientation: ☐ Straight ☐ Gay ☐ Lesbian
☐ Bisexual ☐ Something else: _____ ☐ Prefer not to answer

Gender Identity*: ☐ Male ☐ Transgender Male/Female-to-Male ☐ Other: _____
☐ Female ☐ Transgender Female/Male-to-Female ☐ Prefer not to answer

**Note: We will endeavor to refer to you as your preferred gender, but please remember that your sex in our system must match your insurance.*

Continued on next page…

Gifford Health Care

Please bring this form with you to your first appointment, along with your medical insurance card(s).

New Patient Registration, continued

Primary Medical Insurance Information

Insurance Name: _____ Effective Date: _____

Policy/ID Number: _____ Group Number: _____

Subscriber Name: _____

Subscriber Birthdate: _____

Insurance is provided to patient by: ☐ Self ☐ Spouse ☐ Parent ☐ Other (specify): _____

Secondary Medical Insurance Information

Insurance Name: _____ Effective Date: _____

Policy/ID Number: _____ Group Number: _____

Subscriber Name: _____

Subscriber Birthdate: _____

Insurance is provided to patient by: ☐ Self ☐ Spouse ☐ Parent ☐ Other (specify): _____

If you have any additional insurance, please let us know and bring your insurance card with you.

Responsible Party Information (who is responsible for paying the bill) – COMPLETE ONLY IF NOT SAME AS PATIENT

Name: First: _____ Middle: _____ Last: _____

Address: _____

SS #: _____ - _____ - _____ Date of Birth: _____ / _____ / _____ Gender: ☐ Male ☐ Female

Relationship to patient: _____

Primary Phone: _____ Secondary Phone: _____

Gifford Health Care

Please bring this form with you to your first appointment, along with a list of your current medications.

New Patient Medical History Form

Name: _____ Date of Birth: _____ Date Form Completed: _____

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

HOSPITALIZATIONS

REASON FOR HOSPITALIZATION	DATE	LOCATION/FACILITY

Continued on reverse…

Name: _____ Date of Birth: _____ Date Form Completed: _____

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation:_____Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pneumonia Vaccine:
Last Flu Vaccine:	Last Zoster Vaccine *(Shingles)*:

FAMILY MEDICAL HISTORY

☐ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

✓ CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other: _____	Other: _____	Other: _____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
Grandmother (mother's side)																		
Grandfather (mother's side)																		
Grandmother (father's side)																		
Grandfather (father's side)																		
Other: _____																		

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Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

As applies to: Gifford Medical Center, Gifford Primary Care (Family & Internal Medicine, Pediatrics, Ob/Gyn-Midwifery), Bethel Health Center, Chelsea Health Center, Rochester Health Center, Gifford Health Center at Berlin, Kingwood Health Center, Sharon Health Center, Twin River Health Center, and Menig Nursing Home

I understand that as part of my healthcare, this organization and its medical staff creates, receives, and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that my health information may be used and disclosed by this organization and its medical staff to carry out my care and treatment, to obtain payment and for this organization's health care operations.

A copy of Gifford's *Joint Notice of Health Information Privacy Practices* is available in all registration areas and online at www.giffordhealthcare.org and provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I have had an opportunity to ask questions about anything I did not understand. I understand that the organization reserves the right to change its notice and practices. If it does so, it will post/provide a new *Joint Notice of Health Information Privacy Practices,* which shall be effective for all protected health information maintained.

I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested: however, if it agrees, it is bound by our agreement. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I hereby consent to this organization and its medical staff using and disclosing my health information for the purposes of my treatment, obtaining payment and for its health care operations.

Signature of Patient or Legal Representative	Effective Date
Print Patient Name	Patient's Date of Birth