Associates in Primary Care, LLC

Kimbery Eugair, MSN, FNP-C
Alma Winther, MSN, AGPCNP-BC
225 South Main Street, Rutland, VT 05701
(802) 770-1850 Fax: (802)770-1851

Today's Date: _____

Name: _____ DOB: _____

Sex: (circle one) M F

Main Reason for today's visit: _____

Allergies: (medications, environmental) Reaction: (anaphylaxis, hives, nausea, etc.)

_____ _____

_____ _____

Medication and dosage: (prescription, over-the-counter, herbals)

_____ _____

_____ _____

_____ _____

Family History: Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism _____ High Cholesterol _____

Cancer, specify _____ High Blood Pressure _____

Heart Attack _____ Stroke _____

Depression/Suicide _____ Drug Abuse _____

Diabetes _____ Mental Health Issues _____

Other _____

Social History:

Who lives at home?

Name	Age	Relationship	Highest Education Level

Are your child's parents: Married O Unmarried O Separated O Divorced O When? _____

Parent 1 occupation _____ Parent 1 employer _____

Parent 2 occupation _____ Parent 2 employer _____

Child care situation: Parent(s) _____
Other (specify who and hours per day): _____

Concerns about your child: Alcohol use _____ Tobacco use _____
Sexual Activity _____ Aggressive Behavior _____

Safety:

Are there guns in the home? Yes O No O

When your child is in the car does he/she use:

An infant seat:	Yes O	No O
A seat belt only:	Yes O	No O
A booster seat:	Yes O	No O

Do you have smoke detectors at home? Yes O No O

Does your child wear a helmet for bike/snow board/ATV/scooter safety? Yes O No O

Sleep:

Hours per night _____ Naps (number and length) _____
Any sleep problems _____

Development: At what age did your child:

Sit alone _____ Walk alone _____ Say words _____

Toilet train (daytime) _____ Girls only: Age at first menstrual period _____

Dental History:

Has your child been seen by a dentist? Yes O If yes, how often? _____ Last visit? _____
No O

Water Source (circle one): City or Well

Immunizations/Infectious Disease:
Please bring your child's immunization records to your appointments

Has your child had: Chickenpox O Measles O Mumps O Rubella O Meningitis O
MRSA O Tuberculosis O

Exposures/Habits:
Any concern about lead exposure (old home/plumbing/peeling paint)? Yes O No O

Do any household members smoke? Yes O No O

Hours per day: TV _____ Computer/Phone_____ Video Games _____

Past medical history:

Please describe any major medical problems and the date(s):

_____

_____

_____

Hospitalizations/Operations (with dates):

_____

_____

_____

Broken bones or severe sprains: _____

_____

School History:

Did/Does your child attend school or pre-school? Yes O No O
Current grade: _____ Name of School: _____

Any concerns about school performance? _____

Any concerns about relationship(s) with: Teacher(s) Yes O No O Student(s) Yes O No O

Sports/Exercise:

Type: _____ How often?: _____ How many minutes?: _____

Review of Symptoms: Please check any symptoms your child currently has or have had in the past month. *Read through every section and check "no problems" if none of the symptoms apply to you.*

- O Fever/chills/excessive sweating
- O Unexplained weight loss/gain
- O Cough/wheeze
- O Chest Pain
- O Hay fever/itchy eyes
- O Squinting/crossed eyes
- O Unusually loud voice/hard of hearing
- O Mouth breathing/snoring
- O Bad breath
    - O Frequent runny nose
- O Problems with teeth/gums
- O Tires easily with exercise
- O Shortness of Breath
- O Fainting
- O Nausea/vomiting/diarrhea
    - O Constipation
- O Blood in bowel movement
- O Bedwetting
- O Pain with urination
- O Discharge: penis or vagina

- O Muscle pain/joint pain
- O Skin rashes
- O Unusual moles
- O Headaches
- O Weakness
- O Clumsiness
- O Speech problems
- O Anxiety/stress
- O Problems with sleep/nightmares
- O Depression
- O Nail biting/thumb sucking
- O Bad temper/breath holding/jealousy
- O Unexplained lumps
- O Easy Bruising/bleeding

Is there anything else we should know about you to help provide your care for your child?

_____

_____

_____

Thank you for taking the time to fill this out.

Notice of Privacy 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.

I. Who We Are

This notice describes the privacy practices of Associates in Primary Care, LLC and our employees. This notice applies to all of the medical records generated by our office.

II. Our Privacy Obligations

We are required by law to maintain the privacy of your health information and provide you with a description of our privacy practices. When we use or disclose health information we are required to abide by the terms of this Notice in effect at the time of the use or disclosure.

III. Electronic Health Records

Associates in Primary Care, LLC use an electronic record to store and retrieve much of your health information. One of the advantages of electronic health records (EHR) is the ability to share and exchange health information among other community health care providers and specialists that may be involved in your care. When Associates in Primary Care, LLC enters your information into the EHR, it may share that information by using shared clinical databases or health information exchanges. Associates in Primary Care may also receive information about you from other health care providers in the community who are involved with your care by using shared databases or health information exchanges. If you have any questions or concerns about the sharing or exchange of your medical information, please discuss them with your provider

IV. Uses and Disclosures With Your Consent or Authorization

a. **Use and Disclosure with Your Consent**. Before we provide medical care, except in an emergency or other special circumstances, we will ask you to read and sign a written consent (Your Consent), authorizing us to use and disclose your health information for the following purposes:

- To provide treatment
- To obtain payment for services
- To support health care operations such as quality improvement and customer service, as described below:

Treatment: We may use your medical information to provide treatment or other services. We may disclose your medical information to health care professionals who are involved in your care.

Payment: We may use and disclose medical information about you for billing purposes. We may also tell your health plan about the treatment you are going to receive to determine whether your plan will cover it.

Health Care Operations: We may use and disclose your medical information for health care system operations. The information will be used to support our ongoing efforts to continually improve our quality of care. We may also use medical information about patients to evaluate the need for new services. We may also disclose information to doctors, nurses, and students for educational purposes. To protect your privacy, we may remove information that identifies you from this information.

b. **Use or Disclosure With Your Authorization**. As described above, Your consent only permits us to use your health information to treat you, receive payment for services, and for health care operations. We may use or disclose your health information for any reason other than these only when (1) you authorize us to use or disclose this information by signing an Authorization Form (Your Authorization) or (2) there is an exception described in Section V below.

V. Uses and Disclosures Without Your Consent or Your Authorization

A. **Use or Disclosure of Health Information without your consent or Your Authorization**. At Associates in Primary Care we may use or disclose your health information without your consent or your authorization under the following circumstances: (1) when you require emergency treatment, (2) when we are required by law to disclose your health information, and (3) when we attempt to obtain your consent but are unable to do so because you are unconscious or otherwise incapacitated and we reasonably infer that you would have consented without these barriers to communication.

B. **Disclosures to Individuals Involved in Your Care or Payment for Your Care.** We may release relevant health information about you to a friend or family member who is involved in your medical care or helps pay for your care.

C. **Judicial and Administrative Proceedings**. We may disclose your health information in the course of a judicial or administrative proceeding

if we receive a legal order or other lawful process requiring us to disclose your health information. We may also disclose limited health information to police or law enforcement officials for identification and location purposes and to assist in criminal investigations.

D. **Health or Safety**. We may disclose your health information if we reasonably believe that disclosure would prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

E. **Workers Compensation.** We may disclose your health information as necessary to comply with the Vermont Workers Compensation Statute.

VI. Your Individual Rights

A. **For Further Information: complaints.** If you want further information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we have made about your health information, you may contact Associates in Primary Care, HIPAA Compliance Officer, 225 South Main Street, Rutland, VT 05701 or call 802-770-1850, or the Vermont State Board of Nursing, or the Secretary of State.

B. **Right to Request Additional Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you. You also have a right to limit or restrict the information we share with a family member or friend.

C. **Right to Receive Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

D. **Right to Inspect and Copy Your Health Information.** You have the right to obtain a copy of your medical information. Usually this includes medical and billing services. If you request a copy of your record you will be charged a fee for each copy.

E. **Right to receive a paper copy of this notice**. Upon request you may obtain a paper copy of this notice, even if you agreed to receive this notice electronically.

VII. Effective Date and Duration of this Notice.

A. Effective Date. This notice describes the privacy policy of Associates in Primary Care, LLC that became effective November 1, 2013.

B. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. You may obtain a new notice by contacting Associates in Primary Care, LLC, 802-770-1850.

Welcome to Associates in Primary Care

Office of Kimberly Eugair, MSN FNP-C and Alma Winther, MSN, ANP-BC

Our Mission

To provide compassionate and professional primary care services to residents of the Rutland region, with a focus on wellness and in following the patient centered medical home model. Associates in Primary Care (AIPC), offers preventive, ethical, evidence based and individualized care to our patients. We accept responsibility for the "whole patient", coordinating care with all providers.

Our Focus

We take every step possible to keep you healthy and provide resources for you to reduce the risk of future disease. This includes, but is not limited to: education, hygiene, diet, genetics, and predisposition. We expect our patients to take charge of their health and give them tools to do so. AIPC and our patients work together, keeping each informed and up to date on all health issues. We will coordinate care if it becomes necessary to refer you to a specialist.

Providers

Kimberly Eugair, MSN, FNP-C, is certified in family practice as an Advanced Practice Registered Nurse Practitioner licensed in the State of Vermont. Kim sees patients of all ages.

Alma Winther, MSN, ANP-BC, is certified in adult practice as an Advanced Practice Registered Nurse Practitioner licensed in the State of Vermont. Alma sees patients 13 years and older.

Office Hours

We are open Monday, Tuesday and Thursday 7:30 am - 5:00 pm, Wednesday and Friday 8:00 am - 5:00 pm. We book appointments 7:30 am through 4:30 pm and we can be reached by telephone from 7:30 am through 4:30 pm. When calling for an appointment for a medical situation, your call will be taken by our clinical staff. You will be asked questions so we can assess the situation and provide the best care.

You will be reminded of your appointment one (1) business day prior to your appointment by telephone or text. If you arrive at your appointment 10 minutes late, it will be at the discretion of the provider if the appointment can be kept or needs to be rescheduled.

The office is closed for 6 major holidays (New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day). Depending on the calendar year we will be closed for additional days at the discretion of the providers.

Medical Forms

There is an administrative fee of $10.00 for completion of all forms such as those required by camps, school, daycare, etc. This fee may be waived if the form is completed as part of an office visit. Please allow 5-7 days to complete.

There is a fee for copying any part of your medical record. The minimum charged is $5.00 to a maximum of $30.00. This fee must be paid prior to receipt of your copies. Allow 30 days for the copying of records.

Records provided to another physician for a referral or consultation will be provided at no charge. If you are leaving the practice, we will transfer records once at no charge.

Cancellations

If you cannot come to your appointment, please cancel 24 hours in advance. If you do not show for an appointment and make no attempt to notify us we reserve the right to discharge you from the practice. A combination of 3 missed and or no showed appointments can result in an automatic discharge.

Communication

Communication is an essential component between AIPC and our patients. We can be reached by telephone at 802-770-1850 and through our patient portal. When you are calling for medical advice only medical staff can help you. When the medical staff is busy with patients, the office staff will take a message and relay the information to the appropriate person. In this situation you can expect a call back within 4 hours. We make every attempt to answer the telephone, but on occasion it could be necessary for you to leave a message.

On occasion, when you call it will be necessary to consult with a provider. During these situations you can expect an answer the same day, except when calling after 3 pm. When medical advice is given via the telephone, either a provider or medical staff will relay the information. These messages will be noted in your chart. Please note: No medical advice will be given through email and/or outside the patient portal.

When calling "after hours" (when the office is closed), call 802-770-1850 and leave a message. The on call provider will return your call within 1 hour. (Please see the "After Hours" section for more details).

Communication via the patient portal will be answered within 4 hours, for normal business hours. The portal will not be monitored in the event the office is closed. When the office is closed, please call 802-770-1850 for medical advice.

If communication is difficult for you, such as a foreign language, ability to hear and or read, we will make every attempt to assist you with this matter for your appointment. Please let our clinical staff know prior to your appointment so we can secure the appropriate assistance.

We ask that you, our patient, update us on all visits with outside providers, such as specialists, urgent care visits and all hospital visits.

After Hours Care

When the office is closed, the phone is routed to an after-hours phone to reach the provider on-call. That provider will return your call within 1 hour. If you can wait until the next business day, please do so. We do not prescribe routine medications after hours. Please call 911 if you have an emergency.

Prescriptions

If you take an ongoing prescription we will ask you to come in at certain intervals, as this is necessary to monitor your response to the medication. We will refill it at that visit. For all other refills, call your pharmacy. The pharmacy will notify us. Upon receipt we will take the appropriate action. Or you can leave a message via our office prescription refill line. Our message will prompt you to the information needed to complete a refill request. Prescription refill requests will be completed within 48 business hours, please plan accordingly.

Referrals

Please check the requirements of your insurance plan, many insurance require prior authorization from your primary and will not accept retroactive referral. Some insurances require an evaluation by us before a referral can be made and have specific specialist's that are "in network". We will do our best to make this as smooth as possible.

Insurance and Payment

We have contracted with the following insurance companies: Medicare, Medicaid, MVP, Blue Cross/Blue Shield, Cigna and Tricare. We will bill additional insurance companies, yet we advise you to contact your company prior to your visit.

Be prepared to show your insurance identification at all visits. Established patients will have 3 days to produce their insurance card. New patients without an insurance card can either reschedule the appointment or be self-pay. Self-pay accounts are expected to pay at the time of service, unless a prior arrangement has been made. Payment will be in accordance with the

self-pay sliding fee scale. Note: self-pay appointments and co-pays are not billed to the patient. There is a $20.00 fee for billing a co-pay.

If you lose your insurance or are having a difficult time paying your bills, please let us know. We can set up an appointment with the office manager to discuss financial arrangements. . The practice can also help patients without insurance by assisting you in connecting with the "Vermont Health Exchange" either locally or using electronic communications.

For patients without health insurance we have a reduced fee. It is necessary to inform us prior to the visit and payment is expected at the time of visit to take advantage of this program.

We reserve the right to increase our rates without prior notice.

Effective January 1, 2016 all open balances over 30 days will be charged a 10% finance charge.

First Appointment

AIPC is actively accepting new patients. In the event the patient is 0-12 years of age, Kimberly Eugair will be the provider. If you are 13 years of age and older, you are free to select either provider. Once the provider is selected all appointments will be with that provider, with the following exceptions:

1. Our provider is not in the office that day. We will offer you an appointment with the provider at the office, or you can choose to wait for your provider.
2. The provider is not on call. Each of our providers takes turns being on call to handle after hour needs.
3. At your discretion, the other provider is available at the time you desire.

When you choose to become a patient of AIPC an appointment to establish is necessary. Upon receipt of your call AIPC will ask to have the following forms completed prior to scheduling an appointment: Demographics, HIPAA, consent to share information, consent to bill and new patient medical forms.

Upon receipt of the completed forms our providers will review the information. Once reviewed you will receive a telephone call to schedule your initial visit. Note: This process can take up to 1 month to complete and our providers are currently scheduling new patients visits a minimum of 4 weeks out.

At your first appointment bring your insurance card and a list of all medications (if you don't have a list, bring the medicine bottles in). This list is a list of all the products you take on a daily, weekly basis, prescription and non prescription.

At this visit we will take a copy of your insurance card. Note: You will be expected to present your insurance card at all visits and update the office on any demographic changes.

Our medical staff will take your blood pressure, temperature, height, weight, review all medications and allergies, review lifestyle habits (i.e. smoking, etc) and note your current medical state. When you are with the provider this information will be reviewed more in depth. Also at the first visit we will obtain your past medical history and family history. Upon completion of the appointment with the provider you will receive a summary of the visit or it may be accessed through our patient portal. You will be asked to complete a medical records request form. This form states you give permission for your former primary care provider to send Associates in Primary Care your records.

If it becomes apparent that you have a chronic or acute condition you will receive informational handouts pertaining to the condition. This information will assist you in understanding the condition and way to assist yourself with the condition.

In the situation we recommend further testing and/or referrals to specialists the results will be given to you either by telephone or at your next appointment. You can expect to have the results within 2 weeks of the office receiving them.

Patient Centered Medical Home

Associates in Primary Care have achieved the national status of becoming a Patient Centered Medical Home.

The Patient Centered Medical Home is a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand.

Authorization to Bill for Services Rendered AND Consent for Treatment

I authorize the release of information, including the diagnosis and copies of records of any treatment or examination rendered to me or my child during the period of such care, to third party payers and/or other health practitioners. I agree that this consent constitutes any permission the Associates in Primary Care and medical staff would otherwise be required to obtain under Vermont laws before so using or described in the Associates in Primary Care Notice of Privacy Practices.

I give my consent for examination, diagnostic procedures, medical treatments and surgical procedures including local anesthesia, as prescribed by my provider. I acknowledge that no guarantees have been made to me regarding the results of the examination and/or treatment.

I authorize and request my insurance company to pay directly to the doctor or doctors, group benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf, or my dependents. I understand that if any of the accounts I am responsible for are sent to a collection agency, I am responsible for all costs incurred through this action.

I understand that this form gives permission for treatment in accordance with the provider's orders.

I also authorize my insurance company or employer to discuss matters related to the payment of claims with the staff at Associates in Primary Care.

If this is a work related incident/injury, I authorize Associates in Primary Care to release information to my employer as deemed necessary for services rendered.

_____

Print Name Date

Signature of Patient/Guardian/Loco Parentis Witness

Associates in Primary Care
225 South Main Street
Rutland, VT 05701
802-770-1850

PATIENT IDENTIFYING DETAILS AND DEMOGRAPHICS

Last Name	First Name	MI	Age	D.O.B.	Preferred Pronoun

Street Address (include Apt. # if applicable	City	State	Zip

Preferred Phone Number	Alternate Phone Number	Sexual Orientation	Extension

Gender:			Preferred Language:
male	female	non-binary	

Race							Ethnicity		
American Indian / Alaskan Native	Asian	black / African American	Native Hawaiian / Pacific Islander	white	Other	Decline	Latino / Hispanic	non Latino / Hispanic	Decline

FAMILY INFORMATION	
Next of Kin:	Patient's Mother's Maiden Name:
Relation to Patient:	Phone:
Address:	

INSURANCE

PRIMARY PAYER	
Payer	Insured ID Number:
Priority	Group Number:
Start Date:	Employer Name:
End Date:	Co-Pay Amount:

SECONDARY PAYER	
Payer	Insured ID Number:
Priority	Group Number:
Start Date:	Employer Name:
End Date:	Co-Pay Amount:

PAYMENT INFORMATION	
Payment preference	Date of Birth:
Guarantor's Relationship to Patient:	Sex:
Guarantor Name:	Social Security Number:
Guarantor Address:	Primary Phone Number: