UPPER VALLEY NATURAL HEALTH CENTER

Patient Registration Form

PATIENT INFORMATION

First Name:_____ MI: ____ Last Name:_____

Previous Name: _____ Date of Birth: _____ Gender: _____

Mailing Address: _____ Street Address: _____

City: _____ State: _____ Zip:_____

Employer/School:_____ E-mail Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone:_____

Emergency Contact: _____ Contact's Phone(s):_____

Emergency Contact is my: (specify relationship) _____

How did you hear about us? ❑ *Friend/Family* ❑ *Medical Referral* ❑ *Newspaper Ad* ❑ *Website* ❑ *Yellow Pages*

RESPONSIBLE PARTY INFORMATION if someone other than the patient is financially responsible for the patient's account.

Name:_____Phone: _____

Street Address: _____

City: _____ State: _____ Zip:_____

INSURANCE INFORMATION Please provide your insurance card(s) for photocopying.

Primary Insurance Company: _____ Insurance Phone: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Patient's Relationship to Subscriber: (check one) ❑ *Self* ❑ *Spouse* ❑ *Child*

Secondary Insurance Company: _____ Insurance Phone: _____

I have a ❑ **Health Savings Account (HSA)** ❑ **Health Reimbursement Arrangement (HRA)** ❑ **Flex Spending Account (FSA)**

PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

This includes amounts due for insurance co-pays and any natural medicines dispensed.

Email consultations and functional labs not covered by insurance are the patient's responsibility.

We accept cash, personal checks and credit cards (MasterCard, Visa, American Express, Discover.)

Returned Checks: There will be a charge of $25 for each returned check.

Cancellations: Please provide at least 24 hours advance notice if an appointment needs to be rescheduled or cancelled.
There is a $50 charge for missed appointments or late cancellations.

(OVER)

UPPER VALLEY NATURAL HEALTH CENTER

Contact Preferences

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). Individuals have the right to request receipt of confidential communications from us by alternative means or at alternative locations.

I wish to be contacted in the following manner: (check all that apply)

TELEPHONE COMMUNICATION: appointment reminders, requests to call office on billing or medical matters

Cell Phone: _____

- ❑ OK to leave message with detailed information
- ❑ Leave office name and call-back number ONLY

Home Phone: _____

- ❑ OK to leave message with detailed information
- ❑ Leave office name and call-back number ONLY

Work Phone: _____

- ❑ OK to leave message with detailed information
- ❑ Leave office name and call-back number ONLY

WRITTEN COMMUNICATION: appointment reminders, lab results, billing statements

- ❑ Mail to my home address
- ❑ Do NOT mail to home address. Please mail to:

_____

_____

EMAIL COMMUNICATION: administrative matters (supplement re-orders, etc.), conversations with physician via email regarding my health care

Email address: _____

- ❑ OK for administrative use
- ❑ OK for medical consultations

I understand that information sent via email is not considered secure and may result in the accidental disclosure of personal health information.

_____
Signature of Patient

_____
Patient's Name (PRINT)

_____
Date

_____
Signature of Guardian / Legal Representative

_____
Name and Title of Guardian / Legal Representative (PRINT)

_____
Date

(OVER)

FOR OFFICE USE ONLY: Record of Disclosures						
Date	Disclosed to Whom	Authorized	Purpose	By Whom Disclosed	Type	Method

Type key: T=Treatment Records, P=Payment Information, O=Healthcare Operations; A=Authorization on file; D=Discretionary

Upper Valley Natural Health Center

Patient Agreement

Please initial each section of this agreement and sign at the end.

CONSENT TO CARE **PATIENT INITIALS: ____**

You are the most important person on your health care team. You are entitled to receive clear and understandable information about the treatment options for your health concerns.

I wish to be treated by the health care provider(s) at Upper Valley Natural Health Center. I understand that this care may include any of the following procedures and therapies as necessary to properly evaluate, diagnose and treat my health concerns: physical exams; diagnostic imaging (X-rays, ultrasound, etc.); venipuncture, Pap smears and other specimen collection for diagnostic labwork; dietary and lifestyle counseling; botanical medicines, homeopathic medicines, nutrient therapy (including oral, intramuscular injection or intravenous infusion); soft tissue and bony manipulations; hormonal therapies and prescription medications.

I understand that I may ask questions regarding my individual treatment and that I am free to refuse any specific procedure or treatment or to terminate care at any time. I have the right to seek a second opinion from another health care professional. With this knowledge, I consent to the routine evaluation and treatment deemed necessary or advisable by the health care provider(s) responsible for my care, realizing that no guarantees have been given to me by Upper Valley Natural Health Center.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION **PATIENT INITIALS: ____**

I agree to authorize Upper Valley Natural Health Center to use and/or disclose my health information as necessary to treat me, to obtain payment for services, and to conduct other internal health care operations as described in the Notice of Privacy Practices.

In addition, I authorize Upper Valley Natural Health Center to disclose my protected health information (PHI) and/or discuss my care with the following specific individuals:

Physicians:_____

Other Healthcare Practitioners: _____

Family Members or other Individuals: _____

AUTHORIZATION TO ASSIGN INSURANCE BENEFITS **PATIENT INITIALS: ____**

If I have health care insurance, I agree that Upper Valley Natural Health Center (UVNHC) may bill these insurers and they may make their payments directly to UVNHC. I understand that I am liable to UVNHC for all related charges, whether or not covered by insurance, and the amount I am charged by UVNHC will be based on the benefits of my individual policy.

STATEMENT OF FINANCIAL RESPONSIBILITY **PATIENT INITIALS: ____**

I acknowledge that I am legally responsible for all charges for the services provided to me by Upper Valley Natural Health Center to the extent that those charges are not covered or paid by my insurance carrier/health plan or other payment source such as Medicare or Medicaid. I understand that my insurance carrier/health plan may not approve or pay for the medical services provided by Upper Valley Natural Health Center. I understand that I am personally responsible for payment of all charges not paid in full, co-payments, policy deductibles, and co-insurance, *except where my liability is limited by contract or State or Federal law*. **(OVER)**

NON-COVERED AND/OR NON-MEDICALLY NECESSARY SERVICES **PATIENT INITIALS: ____**

I acknowledge that I am legally responsible for all charges associated with the provision of non-covered and/or non-medically necessary services. I understand Upper Valley Natural Health Center is not responsible for ensuring that I understand which services are not covered or are not considered medically necessary by my insurance carrier/health plan *except where required by contract or State or Federal law*. I understand it is my responsibility to review my insurance plan benefits and accept responsibility for payment should I choose to proceed with care.

PATIENT POLICIES **PATIENT INITIALS: ____**

I acknowledge that I have received and understand the policies for patients as written in the Welcome Letter.

_____	_____
Signature of Patient	**Signature of Guardian / Legal Representative**
_____	_____
Patient's Name (PRINT)	Name and Title of Guardian / Legal Representative (PRINT)
_____	_____
Date	Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been offered a copy of Upper Valley Natural Health Center's Notice of Privacy Practices that outlines the types of uses and disclosures that may occur involving my protected health information, describes my rights, and explains how I may exercise those rights. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that if I have questions or complaints, I may contact the Upper Valley Natural Health Center at 802-281-6989. I also understand that I am entitled to receive updates upon request if Upper Valley Natural Health Center amends or changes its Notice of Privacy Practices in a material way.

_____	_____
Signature of Patient	**Signature of Guardian / Legal Representative**
_____	_____
Patient's Name (PRINT)	Name and Title of Guardian / Legal Representative (PRINT)
_____	_____
Date	Date

FOR OFFICE USE ONLY: Unable to Obtain Acknowledgement of Receipt

This section serves as a record of Upper Valley Natural Health Center's good faith effort to obtain written acknowledgement from the patient of receipt of the Notice of Privacy Practices. Patient was given a copy of the notice on: _____.

❑ Patient refused to sign acknowledgement.
❑ Patient is physically unable to sign acknowledgement.
❑ Other: _____

Upper Valley Natural Health Center

Adult Health History

First Name: _____ MI: ____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ Age: _____ Gender: _____

How do you self-identify? _____

Present Health Concerns: *Please list your top 2 health concerns, including date of onset and severity.*

1. _____

2. _____

What do you believe is causing your most important health concerns? _____

_____

What goals do you have for your visit today? _____

_____

Healthcare Practitioners: *Please list your current medical practitioners with their contact information.*

	Practitioner's Name	Office Name	City	Phone
Primary Care				
OB/Gyn				
Pharmacy				

Medications: *Please list all prescription drugs, over-the-counter medications, and supplements (vitamins, minerals, nutrients, herbs, homeopathic remedies, etc.) that you are currently taking.*

Medication/Supplement	Reason	Date began	Dose/Timing

Allergies: *Please list and describe any severe or life-threatening allergies (medications, stings, foods, etc.):*

❍ NONE or _____ **(OVER)**

Review of Systems: *Check ☑ symptoms that you <u>currently</u> experience.*

Constitutional	Heart & Circulation	Stomach & Digestion	FEMALE Reproductive
Max weight:_____ Year: ____	❍ Heart murmur	❍ Bad breath	Last menstrual period: _____
Min weight: _____ Year: ____	❍ Irregular heartbeat	❍ Excessive thirst	Age period started: _____ yrs
Current height:_____ wt:_____	❍ Heart palpitations	❍ Difficulty swallowing	Length of flow: _____ days
❍ Appetite *or* Weight change	❍ Chest pain	❍ Indigestion	Length of cycle: _____ days
❍ Fevers *or* Chills	❍ Lightheaded	❍ Belching	# Pregnancies: _____
❍ Sweats	❍ Fainting	❍ Heartburn *or* Reflux	# Live births: _____
❍ Feeling hot *or* cold	❍ Deep leg pain on walking	❍ Nausea	# Miscarriages: _____
❍ Fatigue	❍ Varicose veins	❍ Vomiting	# Abortions: _____
❍ Weakness	❍ Swelling of feet / ankles	❍ Abdominal pain *or* cramping	Last Pap smear: _____
Eyes	❍ Cold hands *or* feet	❍ Gas *or* Bloating	Last Mammogram: _____
❍ Eye pain	❍ Easy bruising	# Bowel movements/ day: ____	Last Bone scan: _____
❍ Poor night vision	**Chest & Lungs**	❍ Constipation	❍ Irregular menstrual cycle
❍ Glasses *or* Contacts	❍ Shortness of breath:	❍ Loose stools *or* Diarrhea	❍ Bleeding between periods
❍ Blurred *or* Double vision	❑At rest ❑Walking ❑Lying down	❍ Mucus in stool	❍ Heavy periods
❍ Cataracts *or* Glaucoma	❍ Wheezing *or* asthma	❍ Blood in stool	❍ Painful periods
❍ Dry eyes	❍ Cough: wet *or* dry	❍ Anal pain *or* itching	❍ Premenstrual syndrome
Ears, Nose, Mouth, Throat	❍ Breast lump *or* pain	❍ Hemorrhoids	❍ Pelvic pain
❍ Ringing in ears	❍ Nipple discharge	❍ Hernia	❍ Abnormal pap smear
❍ Earaches	❍ I do self breast exams	❍ Jaundice	❍ Vaginal discharge
❍ Itchy ears	**Neurological**	**Muscles & Joints**	❍ Vaginal itching *or* soreness
❍ Excessive ear wax	❍ Dizziness	❍ Neck pain	❍ Sores on genitals
❍ Hearing loss *or* hearing aid	❍ Poor balance	❍ Back pain	❍ Infertility
❍ Nosebleeds	❍ Poor coordination	❍ Morning stiffness: ___hours	❍ Sexual difficulties
❍ Stuffy *or* Runny nose	❍ Tremors *or* shaking	❍ Joint Pain: *indicate* **R** *or* **L**	❍ Pain with intercourse
❍ Postnasal drip	❍ Seizures	❍ wrist ❍ fingers	❍ Menopausal symptoms
❍ Sinus problems	❍ Headaches	❍ elbow ❍ shoulder	❍ Hormone Replacement
❍ Change in taste *or* smell	❍ Numbness *or* tingling	❍ hip ❍ knee	**MALE Reproductive**
❍ Snoring *or* Sleep apnea	❍ Nerve pain	❍ ankle ❍ foot	❍ Sores on genitals
❍ Teeth *or* Gum problems	❍ Memory loss	❍ Joint swelling	❍ Discharge
❍ Dentures	❍ Brain fog	❍ Joint replacements	❍ Testicle lump/swelling/pain
❍ Grinding teeth	❍ Poor concentration	❍ Muscle pain	❍ Prostate problems
❍ Mouth sores	❍ Hyperactivity	❍ Muscle weakness	❍ Infertility
❍ Dry mouth	❍ Impulsivity	❍ Muscle cramps	❍ Sexual difficulties
❍ Sore throat	❍ Changes in speech	**Skin, Hair, Nails**	❍ I do self testicular exams
❍ Hoarseness	**Mental & Emotional**	❍ Acne	**Bladder & Kidney**
❍ Lump in throat	❍ Mood swings	❍ Dry skin *or* Itchy skin	❍ Frequent / Urgent urination
❍ Jaw clicking *or* pain	❍ Anger, frustration, irritability	❍ Rashes *or* Hives	❍ Painful urination
Immune System	❍ Sadness *or* depression	❍ Flushing *or* Discoloration	❍ Blood *or* Pus in urine
❍ Frequent infections	❍ Suicidal thoughts /self-harm	❍ Moles *or* Growths	❍ Recurrent infections
❍ Sensitivity to foods	❍ Anxiety *or* worry	❍ Poor wound healing	❍ Waking to urinate
❍ Sensitivity to chemicals	❍ Phobias *or* obsessions	❍ Hair loss	❍ Interrupted flow
❍ Lymph gland swelling / pain	❍ Insomnia *or* disrupted sleep	❍ Nail problems	❍ Loss of bladder control

Past Medical History: *Please list the date of or your age at each event.*
Serious Illnesses and Injuries: _____

Surgeries: _____

Hospitalizations: _____

Date of last annual physical: _____ Blood tests: _____ Colonoscopy: _____

Childhood Illnesses: *Please check all that apply:* Your health as a child was: ❑ Good ❑ Fair ❑ Poor

❍Chicken Pox	❍Measles	❍Pneumonia	❍Scarlet Fever
❍Diphtheria	❍Mononucleosis	❍Polio	❍Strep Throat
❍Ear Infections	❍Mumps	❍Rheumatic Fever	
❍German Measles	❍Whooping cough	❍Tonsillitis	

Personal and Family Medical History: *Check ☑ each condition that applies to you and your biological family.*

KEY: P=Paternal; **M**=Maternal **GF**=Grandfather; **GM**=Grandmother		**Parents**		**Grandparents**				**Siblings or Children**				
	YOU	**Mom**	**Dad**	**MGM**	**MGF**	**PGM**	**PGF**					
AGE ⇨												
☑ Check if DECEASED ⇨		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anemia												
Bleeding *or* Clotting Disorder												
Seasonal Allergies												
Eczema												
Asthma												
COPD / Emphysema												
Diabetes												
Thyroid disorder												
Osteoporosis												
Arthritis / Joint Disease												
Autoimmune Disease												
Celiac Disease												
Crohn's Dis. / Ulcerative Colitis												
Liver Disease / Hepatitis												
Gall Bladder Disease												
Kidney Stones *or* Disease												
Heart Attack / Heart Disease												
High Blood Pressure												
High Cholesterol												
Stroke												
Migraines												
Epilepsy *or* Seizures												
Alzheimer's *or* Dementia												
Tobacco / Alcohol / Drug Abuse												
Disordered Eating *or* Exercising												
Abuse *or* Trauma												
Anxiety / Panic Attacks / PTSD												
Depression / Suicide attempt												
Schizophrenia												
Cancer *(what type?)*												
Agricultural *or* Toxin Exposure												
Other:												

Social History

Marital status: ☐ Single ☐ Significant Other ☐ Married / Civil Union ☐ Divorced ☐ Widowed

Years: ____ My relationship is: ☐ Physically Unsafe ☐ Emotionally Unsafe ☐ Loving ☐ Supportive

Do you have any children? ❍ Yes ❍ No Please list their age(s): _____

Household: ☐ Alone ☐ Roommate(s) ☐ Spouse/Significant other ☐ Children ☐ Grandchildren ☐ Parent

Education level: ❍ High school ❍ College ❍ Graduate school ❍ Other: _____

Occupation: ☐ Student ☐ Work ☐ Homemaker ☐ Unemployed ☐ Volunteer ☐ Retired ☐ Disability

School/Job(s): _____ Hours per week: _____

Memories of your childhood: ☐ Mostly happy ☐ Mostly painful ☐ Normal ☐ Don't recall

Do you find your life: ☐ Unsatisfactory ☐ Too demanding ☐ Boring ☐ Satisfactory ☐ Wonderful

Lifestyle and Personal Habits:

What are your primary sources of stress? _____

How much does stress impact your life? _____ Hours of play & relaxation per week? _____

How do you manage stress and take care of yourself? _____

Are you:

Currently sexually active? ❍ Yes ❍ No Partners: # ___ ☐ Male ☐ Female Contraception: _____

Satisfied with your sex life? ❍ Yes ❍ No If no, why? _____

Satisfied with your social life? ❍ Yes ❍ No If no, why? _____

Satisfied with your spiritual life? ❍ Yes ❍ No If no, why? _____

Satisfied with your work? ❍ Yes ❍ No If no, why? _____

Do you:

Exercise regularly? ❍ Yes ❍ No If no, why? _____

Which activities? _____

Sleep soundly and wake rested? ❍ Yes ❍ No If no, why? _____

Use tobacco? ❍ Yes ❍ No Quit date_____ Total years: _____ Amount /day: ____

Drink alcohol? ❍ Yes ❍ No Quit date_____ Type: _____ Drinks /week: _____

Use non-prescribed drugs? ❍ Yes ❍ No Quit date_____ Type: _____ How often: _____

Drink caffeinated beverages? ❍ Yes ❍ No Type? _____ Drinks /day: _____

Have guns or other weapons in your home? ❍ Yes ❍ No Are they stored securely? ❍ Yes ❍ No

Diet: *Please describe your typical meals.*

Breakfast *Time*:_____	Lunch *Time*:_____	Dinner *Time*:_____	Snacks *Times*:_____

Do you have any dietary restrictions? _____

Protein Sources: ☐ Beef ☐ Pork ☐ Poultry ☐ Fish ☐ Shellfish ☐ Eggs ☐ Dairy ☐ Soy ☐ Beans ☐ Nuts

How often do you eat out? _____ What are your food cravings? _____

Water: _____ ounces per day Other beverages: _____

This form has been reviewed by the physician with the patient. _____

Physician Signature Date

UPPER VALLEY NATURAL HEALTH CENTER

Rebecca Chollet, ND

2456 Christian Street

White River Junction, VT 05001

Phone (802) 281-6989 • Fax (802) 281-6988

Our Fees

as of January 1, 2024

Under the federal No Surprises Act, health care providers are required to give an estimate of the total cost of medical services to patients who self-pay in order to protect patients from unexpected medical bills. **If you are uninsured, if you choose not to use your health insurance, or if Dr. Becky Chollet is out-of-network with your plan, you may request a written Good-Faith Estimate for any service you wish to schedule at our office.**

As a streamlined solution to this requirement, we are disclosing our fees for typical office visits, procedures, and lab services that Dr. Becky provides at the Upper Valley Natural Health Center.

New Patient – First Office Visit			
Complexity	**Time**	**CPT**	**Fee**
Straightforward	15 – 19 min	99202	*115.*^{00}
Low	30 – 44 min	99203	*170.*^{00}
Moderate	45 – 59 min	99204	*245.*^{00}
High	60 – 74 min	99205	*306.*^{25}
Established Patient – Follow-Up Office Visits			
Complexity	**Time**	**CPT**	**Fee**
Straightforward	10 – 19 min	99212	*75.*^{00}
Low	20 – 29 min	99213	*120.*^{00}
Moderate	30 – 39 min	99214	*170.*^{00}
High	40 – 54 min	99215	*237.*^{50}
Prolonged Office Visit	15 min	99417	*87.*^{50}
Prolonged Indirect Care	30 – 74 min	99358	*170.*^{00}
Established Patient - Telehealth Phone Visits			
Brief	5 – 10 min	99441	*30.*^{00}
Straightforward	11 – 19 min	99442	*60.*^{00}
Low	20 – 20 min	99443	*96.*^{00}
Procedures		**CPT**	**Fee**
Earwax Extraction (one ear)		69210	*85.*^{00}
Injection		96372	*35.*^{00}
Finger Stick		36416	*12.*^{50}
In-Office Labs		**CPT**	**Fee**
Urinalysis - Dipstick		81002	*5.*^{00}
Rapid Strep		87880	*30.*^{00}
POS Blood Glucose – Finger		82962	*11.*^{25}

<u>Please note</u>:

- Specific service(s) from the above list are chosen at the end of your visit based on an industry-wide standard that considers complexity of medical decision making and time devoted to care.

- In-network insurance contracts may limit allowable rates below our posted fees, which may provide you some savings.
- Only some insurance plans cover audio-only telehealth visits (phone visits). In most cases, patients are charged our typical non-covered phone visit fee of $45 per 15 min interval.
- Patients who self-pay are eligible for a 20% discount off these fees when payment is made in full on the day of the service.

Additional Costs

Dr. Becky may recommend lab tests or imaging studies to be performed at local medical facilities. If you elect to do the test(s), the facility you choose to use is responsible for billing and providing fee estimates. Dr. Becky may also recommend out-of-pocket functional lab tests. She would inform you of the associated cost and if you choose to do a functional lab test, you would pay the lab directly.

Dr. Becky may recommend specific natural medicines for your health needs. We maintain a natural medicine dispensary from which you may choose to purchase your prescribed natural medicines. Alternatively, you may opt to purchase natural medicines elsewhere.

I understand that I am financially responsible for my medical expenses incurred at the Upper Valley Natural Health Center to the extent that my health insurance does not pay for the services provided. I acknowledge that I have been informed of the fees for the services offered at the Upper Valley Natural Health Center.

_____ _____

Signature of Patient **Signature of Guardian / Representative**

_____ _____

Patient's Name (PRINT) Name of Patient's Guardian / Representative (PRINT)

_____ _____

Date Relationship to Patient / Representative Authority

_____

Date

UPPER VALLEY NATURAL HEALTH CENTER

REBECCA CHOLLET, ND

2456 Christian Street, Suite 102

White River Junction, VT 05001

Phone (802) 281-6989 • Fax (802) 281-6988

Telemedicine and Telephonic Services Informed Consent

Patient Name: _____ Date of Birth: _____

Patient Location (town and state): _____

Provider: Rebecca Chollet, ND (VT License #099-0000162; NH License #44)
Provider's Physical Office Location: 2456 Christian Street, Suite 102, White River Junction, VT 05001

I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different site than the provider. Telephonic services are health care services rendered over the phone. Telemedicine and telephonic services may be used as allowed by an individual's health insurance policy when the provider deems such virtual services medically appropriate.

I hereby consent to Dr. Rebecca Chollet of the Upper Valley Natural Health Center delivering health care services to me via telemedicine or telephone.

I understand that my insurance will be billed for telemedicine and/or telephone visits and that I will be responsible for any copayments, co-insurances, and/or deductible amounts that apply to my visits.

I understand that the Upper Valley Natural Health Center cannot guarantee the coverage of my telemedicine and/or telephone visits by my health insurance. **If my insurance denies coverage, despite the best efforts of the Upper Valley Natural Health Center to determine coverage in advance of the visit, I agree to be financially responsible for the cost of the visit.** (This does not apply to Green Mountain Care/VT Medicaid.)

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine and telephonic services and that my insurance carrier will have access to my telemedicine and telephone visit medical records for quality review/audit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine and/or telephonic services in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting the Upper Valley Natural Health Center at 802-281-6989.

As long as my consent has not been revoked, Dr. Rebecca Chollet of the Upper Valley Natural Health Center may provide health care services to me via telemedicine or telephone without the need for me to sign another consent form.

_____ _____

Signature of Patient **Signature of Guardian / Representative**

_____ _____

Patient's Name (PRINT) Name of Patient's Guardian / Representative (PRINT)

_____ _____

Date Relationship to Patient / Representative Authority

_____

Date