

UPPER VALLEY NATURAL HEALTH CENTER

Adolescent Patient Registration Form

This registration form is to be completed by a parent, guardian, or other legal representative of the patient.

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 the patient's: (specify relationship) _____

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

RESPONSIBLE PARTY INFORMATION Please identify the individual(s) financially responsible for the patient's account.

Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION Please provide the patient's 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 Child

Secondary Insurance Company: _____ Insurance Phone: _____

There is 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.

Patient's Name (PRINT)

Signature of Parent / Guardian / Legal Representative

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

Relationship to Patient

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

PARENT/ GUARDIAN INITIALS: _____

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 and intramuscular injection); soft tissue and bony manipulations; hormonal therapies and prescription medications.

I am entitled to receive clear and understandable information about the treatment options for my health concerns. 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

PARENT /GUARDIAN 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

PARENT /GUARDIAN 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

PARENT / GUARDIAN 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

PARENT / GUARDIAN 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

PARENT / GUARDIAN INITIALS: _____

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

Patient's Name (PRINT)

Signature of Parent / Guardian / Legal Representative

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

Relationship to Patient

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.

Patient's Name (PRINT)

Signature of Parent / Guardian / Representative

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

Relationship to Patient

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

Adolescent Health History

First Name: _____ MI: _____ Last Name: _____

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

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 healthcare practitioners with their contact information.*

	Practitioner's Name	Office Name	City	Phone
Primary Care				
Pharmacy				

Medications: *Please list all prescription drugs and 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

Past Medical History: *Please list the date of or age at each event and describe.*

Serious Illnesses and Injuries: _____

Surgeries: _____

Hospitalizations: _____

Date of last physical: _____ Date of last blood tests: _____

Allergies: *please list any severe or life-threatening allergies to medications, stings, foods, etc.:*

NONE or _____ (OVER)

Review of Systems: Check the symptoms that you currently experience. (to be filled out with/by patient)

Constitutional	Heart & Circulation	Digestion & Intestine	Female Reproductive
Max weight: _____ Year: _____	<input type="radio"/> Heart murmur	<input type="radio"/> Bad breath	Last menstrual period: _____
Min weight: _____ Year: _____	<input type="radio"/> Irregular heartbeat	<input type="radio"/> Excessive thirst	Age period started: _____ yrs
Current height: _____ wt: _____	<input type="radio"/> Heart palpitations	<input type="radio"/> Difficulty swallowing	Length of flow: _____ days
<input type="radio"/> Appetite or weight change	<input type="radio"/> Chest pain	<input type="radio"/> Indigestion	Length of cycle: _____ days
<input type="radio"/> Fevers or Chills	<input type="radio"/> Lightheaded	<input type="radio"/> Belching	# Pregnancies: _____
<input type="radio"/> Sweats	<input type="radio"/> Fainting	<input type="radio"/> Heartburn or Acid Reflux	# Live births: _____
<input type="radio"/> Feeling hot or cold	<input type="radio"/> Cold hands or feet	<input type="radio"/> Nausea	# Miscarriages: _____
<input type="radio"/> Fatigue	<input type="radio"/> Swelling of feet / ankles	<input type="radio"/> Vomiting	# Abortions: _____
<input type="radio"/> Weakness	<input type="radio"/> Easy bruising	<input type="radio"/> Abdominal pain or cramping	Last Pap smear: _____
Eyes	<input type="radio"/> Blood transfusions	<input type="radio"/> Gas or Bloating	<input type="radio"/> Irregular menstrual cycle
<input type="radio"/> Eye pain	Chest & Lungs	# Bowel movements/ day: _____	<input type="radio"/> Bleeding between periods
<input type="radio"/> Blurred or Double vision	<input type="radio"/> Shortness of breath	<input type="radio"/> Constipation	<input type="radio"/> Heavy periods
<input type="radio"/> Glasses or Contacts	At rest Walking Lying down	<input type="radio"/> Loose stools or Diarrhea	<input type="radio"/> Painful periods
Near or Far sighted	<input type="radio"/> Wheezing or asthma	<input type="radio"/> Mucus in stool	<input type="radio"/> Premenstrual syndrome
<input type="radio"/> Dry eyes	<input type="radio"/> Cough: wet or dry	<input type="radio"/> Blood in stool	<input type="radio"/> Pelvic pain
Ears, Nose, Mouth, Throat	<input type="radio"/> Breast lump or pain	<input type="radio"/> Rectal pain/itching	<input type="radio"/> Abnormal pap smear
<input type="radio"/> Ringing in ears	<input type="radio"/> Nipple discharge	<input type="radio"/> Hemorrhoids	<input type="radio"/> Vaginal discharge
<input type="radio"/> Earaches	<input type="radio"/> I do self breast exams	<input type="radio"/> Hernia	<input type="radio"/> Vaginal itching or soreness
<input type="radio"/> Itchy ears	Neurological & Cognitive	<input type="radio"/> Jaundice	<input type="radio"/> Sores on genitals
<input type="radio"/> Excessive ear wax	<input type="radio"/> Dizziness	Muscles, Bones & Joints	Male Reproductive
<input type="radio"/> Hearing loss or hearing aid	<input type="radio"/> Poor balance	<input type="radio"/> Neck or Back pain	<input type="radio"/> Sores on genitals
<input type="radio"/> Nosebleeds	<input type="radio"/> Poor coordination	<input type="radio"/> Joint Pain: indicate R or L	<input type="radio"/> Discharge
<input type="radio"/> Stuffy or Runny nose	<input type="radio"/> Tremors or shaking	<input type="radio"/> wrist	<input type="radio"/> fingers
<input type="radio"/> Postnasal drip	<input type="radio"/> Seizures	<input type="radio"/> elbow	<input type="radio"/> shoulder
<input type="radio"/> Sinus problems	<input type="radio"/> Headaches	<input type="radio"/> hip	<input type="radio"/> knee
<input type="radio"/> Change in taste or smell	<input type="radio"/> Numbness or tingling	<input type="radio"/> ankle	<input type="radio"/> foot
<input type="radio"/> Dental cavities	<input type="radio"/> Nerve pain	<input type="radio"/> Joint swelling	Bladder & Kidney
<input type="radio"/> Grinding teeth	<input type="radio"/> Poor memory	<input type="radio"/> Morning stiffness: ___ hours	<input type="radio"/> Frequent / Urgent urination
<input type="radio"/> Gum problems	<input type="radio"/> Poor concentration or focus	<input type="radio"/> Joint replacements	<input type="radio"/> Painful urination
<input type="radio"/> Mouth sores	<input type="radio"/> Spaciness or distractibility	<input type="radio"/> Muscle pain	<input type="radio"/> Blood or pus in urine
<input type="radio"/> Dry mouth	<input type="radio"/> Hyperactivity	<input type="radio"/> Muscle weakness	<input type="radio"/> Recurrent infections
<input type="radio"/> Jaw clicking or pain	<input type="radio"/> Impulsivity	<input type="radio"/> Muscle cramps	<input type="radio"/> Waking to urinate
<input type="radio"/> Sore throat	<input type="radio"/> Learning disability	Skin, Hair, Nails	<input type="radio"/> Interrupted flow
<input type="radio"/> Hoarseness	Mental & Emotional	<input type="radio"/> Acne	<input type="radio"/> Kidney stones
<input type="radio"/> Lump in throat	<input type="radio"/> Mood swings	<input type="radio"/> Itching or Dry skin	<input type="radio"/> I wear a seatbelt
Immune System	<input type="radio"/> Anger, frustration, irritability	<input type="radio"/> Rashes or Eczema	<input type="radio"/> I wear bike/ski/skate helmet
<input type="radio"/> Frequent infections	<input type="radio"/> Sadness or depression	<input type="radio"/> Hives	<input type="radio"/> There are guns or weapons at home
<input type="radio"/> Allergies to environment	<input type="radio"/> Suicidal thoughts	<input type="radio"/> Moles or growths	<input type="radio"/> Secure storage
<input type="radio"/> Sensitivity to foods	<input type="radio"/> Self-harm (cutting, etc.)	<input type="radio"/> Poor wound healing	I have trouble or feel unsafe at:
<input type="radio"/> Sensitivity to chemicals	<input type="radio"/> Anxiety, worry or phobias	<input type="radio"/> Hair loss	<input type="radio"/> Home <input type="radio"/> School <input type="radio"/> Work
<input type="radio"/> Lymph gland swelling / pain	<input type="radio"/> Insomnia or disrupted sleep	<input type="radio"/> Nail problems	<input type="radio"/> I feel unhappy @ my looks
			<input type="radio"/> I have 1 adult I can talk to

- Childhood Illnesses:** *Please check all that apply.* As a child, your health was: Good Fair Poor
- Chicken Pox
 - Diphtheria
 - Ear Infections
 - German Measles (Rubella)
 - Measles
 - Mononucleosis (Mono)
 - Mumps
 - Pertussis (whooping cough)
 - Pneumonia
 - Polio
 - Rheumatic Fever
 - Tonsillitis
 - Scarlet Fever
 - Strep Throat (recurrent)

Immunizations: All immunizations up to date Delayed schedule Refused all immunizations

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				
	YOU	Mom	Dad	MGM	MGF	PGM	PGF					
<i>AGE</i> ⇒												
<input checked="" type="checkbox"/> Check if DECEASED ⇒		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?)												
Other:												

This page is to be filled out with or by the patient.

Social History

Parents: Biological Adoptive Foster Step-parent(s)
Parents' Marital Status: Single Significant Other Married / Civil Union Divorced Widowed
Parent's Occupation: _____ Full or Part Time Parent's Occupation: _____ Full or Part Time
Siblings: Yes No Please list their age(s) _____
Household: Parent(s) Sibling(s) Grandparent(s) Other _____
Romantic Relationship: Single Significant Other for ____ years
My relationship is: Physically Unsafe Emotionally Unsafe Safe and Supportive
School / Training Program: _____ Current grade level: _____
Non-Academic Activities: Sports Work Volunteer Other _____
Memories of your childhood: Mostly happy Mostly painful Normal Don't recall
My life is: Unsatisfactory Too demanding Boring Satisfactory Wonderful

Lifestyle and Personal Habits:

How do you self-identify? _____ Pronouns? _____
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 Age of 1st Sexual Activity: ____ Current # of Partners: ____
My partner/s is/are: Male Female Form of Contraception/STI protection: _____
Satisfied with your social life? Yes No If no, why? _____
Satisfied with school/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 or vape? Yes No Quit date _____ Total years: ____ Amt. /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: ____

Diet: *Please describe your typical meals.* Dietary restrictions: _____

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

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 doctor with the patient and parent/guardian. _____
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 new 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

Please note:

- 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 the medical expenses incurred at the Upper Valley Natural Health Center to the extent that my child's health insurance does not pay for the services provided to my child. I acknowledge that I have been informed of the fees for the services offered at the Upper Valley Natural Health Center.

Patient's Name (PRINT)

Signature of Parent /Guardian / Legal Representative

Name of Parent / Guardian / Legal Representative (PRINT)

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.

Patient's Name (PRINT)

Signature of Parent / Guardian / Legal Representative

Name of Parent / Guardian / Legal Representative (PRINT)

Relationship to Patient

Date