Good Neighbor Health Clinic
Red Logan Dental Clinic
July 2023

PO Box 1250
White River Junction, VT 05001
Phone: (802) 295-7573
Fax: (802) 359-1020
Website: www.goodnhc.org
Medical Clinic: medical@goodnhc.org
Dental Clinic: dental@goodnhc.org

I am applying to the (check all that apply): ❑ Dental Clinic ❑ Medical Clinic ❑ Eye Clinic

Patient Information

Title: ❑ Mr ❑ Ms ❑ Mrs ❑ Mx ❑ Other: _____

Last Name: _____ Legal First Name: _____ Middle Initial:___

Preferred name: _____

DOB (month/day/year): _____/_____/_____ Age: _____ SSN: _____-_____-_____

Race: _____ Languages spoken at home:_____

Pronouns:
- ☐ She/her
- ☐ He/him
- ☐ They/them
- ☐ Write in:_____

Gender Assigned at Birth:
- ☐ Female
- ☐ Male
- ☐ Unsure
- ☐ Intersex

Gender:
- ☐ Female
- ☐ Male
- ☐ Transgender
- ☐ Genderqueer
- ☐ Agender
- ☐ Genderfluid
- ☐ Unsure
- ☐ Non-binary
- ☐ Intersex
- ☐ Write in: _____

Sexual Identity (check all that apply):
- ☐ Straight/Heterosexual
- ☐ Lesbian/Gay/Homosexual
- ☐ Bisexual
- ☐ Pansexual
- ☐ Polysexual
- ☐ Queer
- ☐ Asexual
- ☐ Unsure
- ☐ Prefer not to answer

Relationship Status:
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ In a relationship, not married
- ☐ In relationship(s) with multiple partners

Relationship Structure:
- ☐ Monogamous
- ☐ Polyamorous
- ☐ Non-monogamous/Open
- ☐ Other: _____

Do you feel safe in your relationship? Yes❑ No❑

Are you sexually active? Yes❑ No❑

Education and Employment Information

Highest Degree of Level of School Completed:
- ☐ Less than high school diploma. Grade:___
- ☐ High school diploma or GED
- ☐ Some college, but no degree
- ☐ Associate's Degree (such as AA, AS)
- ☐ Bachelor's Degree (such as BA, BS)
- ☐ Master's Degree, Professional Degree, or Doctorate (such as MA, MD, PhD)

Employment Status:
- ☐ Full time
- ☐ Part-time
- ☐ Self Employed
- ☐ Seasonal/Temp
- ☐ Unemployed
- ☐ Retired
- ☐ Disabled

If employed, where? _____ Work phone (_____) _____-_____

Is it okay for us to call you at work? Yes ❑ No ❑

Have you served in the Military? Yes ☐ No ☐ If yes, what branch? _____

Housing Information

Housing Status: Rent ❑ Own ❑ Temporary Housing ❑ Unhoused❑

Have you ever run out of food by the end of the month? Yes❑ No❑

Have you ever worried about running out of food? Yes❑ No❑

Mailing Address: _____

Town: _____ State: _____ Zip Code: _____

Physical Address: _____

Town: _____ State: _____ Zip Code: _____

Contact Information

Home phone: (_____): _____ - _____ Cell: (_____) _____- _____

Email Address:_____

What is the best way for us to contact you? Home❑ Cell❑ Work❑ Email❑ Other: _____

Emergency Contact Name**:** _____ Relationship: _____

Phone (_____) _____-_____

Medical Information

Preferred Pharmacy**:** _____ Location**:** _____

Do you have health insurance?

- ☐ Yes
- ☐ No

If yes, what type?

- ☐ Medicare
- ☐ VT Medicaid
- ☐ NH Medicaid
- ☐ Write in: _____

Do you have dental insurance?

- ☐ Yes
- ☐ No

If yes, what type?

- ☐ Medicare
- ☐ VT Medicaid
- ☐ NH Medicaid
- ☐ Write in: _____

Do you have a Primary Care Provider (outside of Good Neighbor Health Clinic)? Yes ❑ No ❑

If yes, please provide name of Provider: _____

Do you smoke or chew tobacco? Yes ❑ No ❑ If yes, Smoke❑ Chew❑ Vape❑

Are you interested in quitting smoking? Yes ❑ No ❑

Have you delayed getting care or medications because of the cost? Yes ❑ No ❑

Where would you go for medical care if you could not come here?

Emergency Dept. at hospital ❑ Another doctor ❑ I wouldn't have gone ❑ I don't know ❑

How did you hear about us?

_____

Household Information

Household Children: How many dependent children under age 18 living at home? _____

Household Total: How many family members total are living in your household?
(You + spouse/partner + dependent children under age of 18 living at home) _____

Income: Household Income (before tax and withholding)	**Per Month:**
Your Income	$_____
Spouse/Partner Income	$_____
Other income (disability income, child support, or public assistance)	$_____

Total household income (before tax) $_____

This application is not complete without proof of income (Pay stub, W-2, Social Security Statement), proof of residency (driver's license or utility bill), and medical history.

I agree the information provided on this form is accurate. I give Good Neighbor Health Clinic permission to verify information (including income, residency and insurance status) contained on this form.

Signature: _____ Date: _____

Good Neighbor Health Clinics

FREE CLINICS FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM

Patient Notice of Limited Liability of

FTCA Deemed Volunteer Free Clinic Health Care Professionals

Malpractice coverage for the Good Neighbor Health Clinics is provided by the Federal Government

Details:

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. §§ 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (o)). Certain free clinic health care professionals providing health care services to patients at this free clinic may be covered by the above Federal law.

Acknowledged:

_____(patient signature)

_____(patient name, printed legibly)

Date: _____

Good Neighbor Health/Red Logan Dental Clinics

70 North Main Street

White River Junction, Vermont 05001

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect 1/21/2021 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of this notice.

Uses and Disclosures of Health Information

We use and disclose health information about you and your treatment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and other performance, conducting training programs, accreditation, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses and disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice.

Disclosure Accounting: You have a right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location.

Electronic Notice: If you receive this Notice on our website or by electronic mail (email), you are entitled to receive this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure or your health information or to have us communicate with you by alternative means or alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officers: Heather Grohbrugge

Telephone: 802-295-1868 Fax 802-295-3600

Email: Heather@goodnhc.org

Address: PO Box 1250, White River Junction, VT 05001

Good Neighbor
Health Clinics

ACKNOWLEDGE RECEIPT OF PRIVACY PRACTICES

***You may refuse to sign this acknowledgement**

I, _____, have seen and was offered a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____Individual refused to sign

____Communications barrier prohibited obtaining the acknowledgement

____An emergency situation prevented us from obtaining acknowledgement

____Other (Please Specify)

October 30, 2023

Red Logan Dental Clinic
Phone: (802) 295-7573
Fax: (802) 359-1020

Good Neighbor Health Clinics

Good Neighbor Health Clinic
Phone: (802) 295-1868
Fax: (802) 295-3600

Authorization for Release of Medical Record and Protected or Privileged Health Information

Patient Name:_____ Date of Birth:_____

Social Security #:_____

I hereby consent to release, disclose obtain, exchange, and/or share my health information among the following:

FROM:	TO:
Facility Name, Address:	Facility Name, Address:
_____	_____
_____	_____
_____	_____

Information to be released (check all that apply)

__ Medical Records
__ Lab/Imaging Reports, Dental x-rays
__ Mental Health Diagnosis and/or Treatment Details
__ Other: _____
__ Alcohol and Drug Record

Purpose of Release (check all that apply)

__ Continuing Care __ Personal __ Insurance __ Legal __ Other:_____

By my signature below, I understand and consent to the following:

- → My health information is protected by federal HIPAA 45 CFR Part 2) and state laws and regulations, and disclosure is allowed only with my authorization, except in limited circumstances described in the facility's Notice of Privacy practices.
- → The facility releasing the information cannot control how the recipient uses or shares the information, and cannot prevent further release by the recipient.
- → I understand releases pursuant to this authorization will identify me as receiving services at this facility.
- → My consent is voluntary and I may revoke this authorization at any time by giving written notice to the facility, except to the extent that action has already been taken in reliance upon it.
- → Unless revoked earlier or otherwise indicated, this authorization will expire one (1) year from the date of signing.
- → A fax or photocopy that has not been altered may be considered as valid as the original.

Patient or Representative: Please make sure all appropriate sections above are completed.

Patient Name:_____ Signature:_____

Relationship to Patient:_____ Date:_____