Associates in Primary Care
T 802-770-1850
F 802-770-1851
98 Allen Street Unit 2
Rutland, VT 05701

Patient Identifying Details and Demographics

Last Name	First Name	MI	Age	D.O.B.	☐ Male ☐ Female

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

Home Phone Number	Cell Phone Number	Work Phone Number	Extension
e-mail address			

How would you like to receive information (circle one)?

Send voice notifications Send text notifications Send e-mail notifications

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
Type	Employer Name
Relationship to the insured	Insurance Payment
Start Date:	Type
End Date:	Payment Type
	Co-Pay Amount
	Status

SECONDARY PAYER

Payer	Insured ID Number:
Priority	Group Number
Type	Employer Name
Relationship to the insured	Insurance Payment
Start Date:	Type
End Date:	Payment Type
	Co-Pay Amount
	Status

PAYMENT INFORMATION

Payment Preference	Date of Birth:
Guarantor's Relationship to Patient:	Sex:
Guarantor Name:	Social Security Number:
Guarantor Address:	Primary Phone Number:
	Secondary Phone Number:

Associates in Primary Care, LLC

98 Allen St. Unit 2,Rutland, VT 05701

Phone: 802-770-1850

Fax: 802-770-1851

Pediatric Health History Form

Name:_____ Date of Birth_____ Age_____

Previous Primary Care Provider:_____

Present Health Concerns:_____

Prescription Medicines:_____

Vitamins/Over the Counter:_____

Herbals/Home Remedies:_____

Allergies to Medications or Vaccinations:_____

Pregnancy and Birth:

Where was your child born? _____

Is the child yours by: Birth_____ Adoption_____ Step child_____ Other:_____

Please indicate any medical problems during pregnancy: None____ Specify_____

_____

Delivery by: Vaginal_____ Caesarean, if Caesarean, why?_____

Birth Weight:_____ Birth length_____ APGAR score 1min_____ 5min_____

Please indicate any medical problems during newborn period? None____Specify_____

If premature, how early?_____

Nutrition and Feeding

Was your child breastfed? No___ Yes____, if so how long?_____

Has your child had any feeding/dietary problems? No___ Yes____, if yes please specify_____

_____

Milk intake now: Type: Cow's milk (nonfat__1%__2%__Whole Milk__) Soy Milk__ Rice Milk___

Average ounces per day (note 8 ounces=1 cup)

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 type	_____	High Blood Pressure	_____
Heart Attack	_____	Stroke	_____
Depression/Suicide	_____	Drug Abuse	_____
Diabetes	_____	Mental Health Illness	_____
Other	_____		

Social History:

Who lives at home?

Name	Age	Relationship	Highest Education Level

Are your child's parents Married___ Unmarried__Separated__ Divorced ___, when?___

Parent 1 occupation_____Parent 1 employer_____

Parent 2 Ocupation_____ Parent 2 Employer_____

Child care situation: Parents _____Others (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___ no ___

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

An infant seat, Yes___ No___ A seat belt only, Yes___ No___ A booster seat, Yes___ No__

Do you have smoke detectors at home? Yes___ No___

Does your child wear a helmet for bike/Snow Board/ATV/Scooter safety? Yes___ No___

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 child been seen by dentist? Yes____ No___, If yes how often_____ Date of last visit_____

Water Source: City or Well_____

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

Has your child had: Chickenpox___ Measles___ Mumps___ Rubella___ Meningitis___ MRSA___

Tuberculosis__

Exposures/habits: Any concerns about lead exposure? (old home/plumbing/peeling paint)Yes___ No___

Do any household members smoke? Yes___.No___

TV hours per day_____ Computer hours per day_____ Video game hours per day_____

Past Medical History: Please describe any major medical problems and their dates.

_____

_____

_____

Hospitalizations/operations (with dates): _____

Broken Bones or severe sprains: _____

School History:

Did/Does your child attend school or preschool? Yes___ No___

Current grade_____ Name of school _____

Any concerns about school performance?_____

Any concerns about relationship with: Teachers Yes__ No__ Students Yes__ No__

Sports/Exercise:

Type_____How often? _____ How many minutes?_____

Review of Systems: Please check any current problems your child has on the list below:

Constitutional

Fevers/chills/excessive sweating

Unexplained weight loss/gain

Eyes

Squinting/crossed eyes

Ears/Nose/Throat

Unusually loud voice/hard of hearing

Mouth breathing/snoring

Bad breath

Frequent runny nose

Problems with teeth/gums

Cardiovascular

Tires easily with exercise

Shortness of breath

Fainting

Respiratory

cough/wheeze

Chest pain

Gastrointestinal

Nausea/vomiting/diarrhea

constipation

Blood in bowel movement

Genitourinary

Bedwetting

Pain with urination

Discharge: penis or vagina

Musculoskeletal

Muscle pain/joint pain

Skin

Rashes

Unusual moles

Allergy

hay fever/itchy eyes

Neurological

Headaches

weakness

clumsiness

Psychiatric/Emotional

speech problems

Anxiety/stress

Problems with sleep/nightmares

Depression

nail biting/thumb sucking

Bad temper /breath holding/jealousy

Blood/Lymph

Unexplained lumps

Easy bruising/bleeding

Thank you for taking the time to fill this out.

Consent to Share Information

I _____ (patient's printed name)

Give my permission to Associates in Primary Care employees to share information regarding my health, including but not limited to; test results, medication updates, office visit notes with _____ (named person).

Give my permission to communicate through email to Associates in Primary Care, LLC employees. I understand that email communication may not be secure and that some information shared may obtain confidential health information. Email address:_____

My preferred method of communication is: _____

Give my permission to leave a message on my home telephone system. Yes_____ No_____

Give my permission to leave a message on my cell phone. Yes _____No_____

Give my permission to leave a message with: _____(named person).

I have been given and read Associates in Primary Care's Hippa statement.

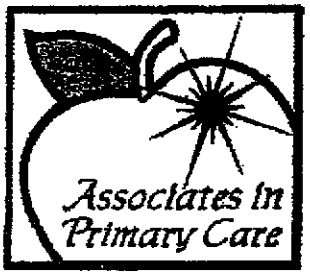
_____ _____

Signature Date

_____

Guardian

Confidentiality notice:
Associates in Primary Care, LLC will follow



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 all of my bills will be sent to the responsible party who is named on my account. I understand that if any of the accounts I am responsible for are set 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 payment of services rendered.

Print Name

Signature of Patient/Guardian/Loco Parentis Date Witness

Associates in Primary Care, LLC
98 Allen St. Unit 2, Rutland, VT 05701
Phone: 802-770-1850
Fax: 802-770-1851

Please:
☐ Fax
☐ Courier
☐ Patient will pick up

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Patient Name (First, Middle, Last)	Date of Birth
Address	Telephone number

Disclosed Information:

☐ Entire Record
☐ Lab Reports
☐ Radiology/X-ray Reports
☐ ECG or cardiac testing
☐ Medication Records
☐ ER Record
☐ Operative Report
☐ History and Physical
☐ Discharge Summary
☐ Consultations
☐ Mental Health Records
☐ Drug/Alcohol treatment
☐ Other (please specify): _____

Information to be provided to/from:

Name of Person or Institution: _____

Address: _____

Telephone/Fax: _____

Purpose/use of Requested information:

☐ Transfer of care
☐ Collaboration with other providers
☐ Personal use by patient
☐ Other (please specify): _____

Authorization:

I hereby authorize Associates in Primary Care, LLC to disclose the health information as described above.
I understand that I may revoke this authorization at any time, and must do so in writing. I understand that revocation will not apply to information that has already been released in response to this authorization.
I understand that for printed records, I may be asked to pay a reasonable fee.
My refusal to sign this authorization will not affect my ability to receive treatment.

_____ _____
Patient or Patient Representative Date

_____ _____
Witness Date

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 be 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.

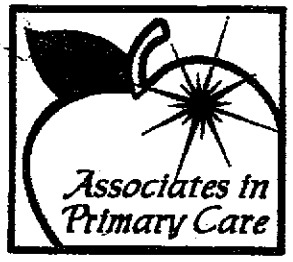
IV. **Uses and Disclosures With Your consent or Authorization**

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 IV 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, Practice Manager and Hippa Compliance Officer, Kathy Boudreau, Monday through Friday at 98 Allen Street Unit 2, 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 or copies 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 described 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 Eugiar, MSN FNP-C and Brooke Larmie, 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. (AIPC), Associates in Primary Care, 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 the 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.

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

Office Hours

We are open Monday through Friday 7:00 AM-5:00PM. We book appointments 7:00AM through 4:30PM and we can be reached by telephone 8:00AM through 4:30PM. 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 to provide the best care.

You will be reminded of your appointment 2 days prior to your appointment by telephone, text or email. If you arrive for 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.

We are closed 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 additional days at the discretion of the providers.

Updated: June 218

After Hours Care

When the office is closed the phone is routed to an after-hours phone to reach the provider on call. We 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 telephone. 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 insurances 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, Tricare, CBA and Cigna. We will bill additional Insurance Companies, yet we advise you to contact the Company prior to the 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 time of service, unless a prior arrangement has been made. Payment will be in accordance to 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 setup 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 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 charges a 10% finance charge.

Updated: June 218

Medical Forms

There is an administrative fee of $10.00 for completion of all forms such as those required by camp, school, day care, 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 up 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 telephone call within 4 hours.

We make every attempt to answer the telephone, but on occasion it could be necessary that you leave a message. All messages will be answered within the hour.

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 3PM. 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 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 "After Hours", on the previous page for more details.)

Updated: June 218

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 in 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.

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 in 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's 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, HIPPA, 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 patient visits a minimum for 4 week out.

At your first appointment bring your insurance card and a list of all medications. (If you do not have a list, bring the medicine bottles.) This list is a list of all products you take on a daily, weekly basis, prescription and nonprescription.

At this visit we will take a copy of your insurance card. Note: You will be expected to present you 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) and collect your current medical status. 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 ways 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 with 2 weeks of the office receiving them.

Patient Center Medical Home

Associates in Primary Care is a Patient Center Medical has achieved the national status of becoming a Patient Center Medical Home.

The Patient-Centered Medical Home (PCMH) 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.

Associates In Primary Care
Kimberly Eugair, MSN, FNP-C *Family Nurse Practitioner*
Brooke Larmie, MSN, ANP-BC *Adult Nurse Practitioner*
Cristin Craft, MSN, AGPCNP-BC *Adult Nurse Practitioner*

Thank you for choosing Associates In Primary Care, LLC as your health care provider. Please review our Financial Policy.

PAYMENT IS DUE AT TIME OF CONSULTATION OR OFFICE VISIT
WE ACCEPT CASH, CHECKS, VISA, MasterCard OR MONEY ORDERS
WE OFFER AN EXTENDED PAYMENT (BUDGET) PLAN. Contact our Billing office to make arrangements at 802-770-1850.

Insurance Policies
Your insurance policy is a contract between you and your insurance company. Professional care is provided to you, our patient and not to an insurance company. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We will gladly process your claim, but we request your estimated portion be paid at the time of service. To do so, we require your complete insurance information. In the event we do accept assignment of benefits, please know that the balance of your bill is still your responsibility whether your insurance company pays or not. If your insurance company has not paid your account in full within 30 days, you will have 30 days to arrange payment of the balance due. Regarding insurance plans in which we are a participating provider, please understand that we do require payment of co-pays and deductibles prior to treatment.

Managed Care Insurance
Patients enrolled in a managed care health plan are expected to remit appropriate co-payment upon arrival at the office for the appointment. After the practice receives payment from the insurance company and discount adjustments have been posted, the patient is responsible for any balance due.

Insurance Authorization and Assignment
I request that payment of authorized insurance benefits be made on my behalf to Associates In Primary Care, LLC for any services furnished me. I hereby authorize Associates In Primary Care, LLC to release any medical information necessary to process my claim. I permit a copy of this authorization to be used in place of the original. The authorization may be revoked either by me or my insurance company at any time in writing.

Missed Appointment Agreement
Patients of this practice will be called the night before regarding their appointment date and time. After doing so, should the patient not show for their scheduled appointment, we will send out a letter stating that they need to reschedule the appointment that they missed. A copy of this letter will be put in the patients chart and kept as a warning. After a warning has been issued and the patient misses another scheduled appointment there will be a charge to the patient. Any patient who has a co-pay will be charged that amount, and for patients with no co-pay there will be a flat fee of $25.00 for each appointment missed there after. it is a patient responsibility to notify the practice if unable to keep their scheduled appointment.

I have read the financial policy. I understand and agree to this Financial Policy.

98 Allen Street, Unit 2 Rutland, VT 05701
Ph: 802-770-1850 • Fax: 802-770-1851 • aiprimarycare@gmail.com