



Amy Thibault, MD  
Jennie Lowell, MD  
Julie Wade, MD  
Kristen Werner, CNM  
Lindsay Smith, MD  
Katherine Areson, MD  
Sarah Peters, MD  
Britta Werner, MD  
Brianna Durkin, NP  
Anna Gluckman NP  
Emily Garcia, NP  
Lorraine Daily, FNP  
Emily Olson, CNM  
Lauren Jarvis, DO

## Registration Form

**(Please complete all sections.)**

**Today's Date:** \_\_\_\_\_

**Primary Care Provider:** \_\_\_\_\_

### PATIENT INFORMATION

**Last Name:** \_\_\_\_\_

**First:** \_\_\_\_\_

**Middle:** \_\_\_\_\_

**Marital status:** \_\_\_\_\_

Is this your legal name?  
 Yes  No

If not, what is your legal name?  
\_\_\_\_\_

**Former name:** \_\_\_\_\_

**Birth date:** \_\_\_\_\_

**Age:** \_\_\_\_\_

**Mailing Address:**  
\_\_\_\_\_

**City/Town:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip:** \_\_\_\_\_

Would you like to use the Patient Portal to access your records, lab results, and have messaging capabilities with our staff? **Yes / No**

**Email:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_

**(Please circle or designate your preferred contact #)**

**Home Phone:** \_\_\_\_\_

**Cell ph#:** \_\_\_\_\_

### **Gender Identity:**

What was the sex assigned to you at birth?

Female

Male

What Gender do you identify with currently?

Female

Male

Genderqueer/non-binary

(Neither exclusively female nor male)

**Preferred Pronouns:** \_\_\_\_\_

### **Race:**

\_\_\_ American Indian or Alaska Native

\_\_\_ Asian

\_\_\_ Black or African American

\_\_\_ Native Hawaiian or Other Pacific Islander

\_\_\_ Hispanic/Latino

\_\_\_ White

**Employer:** \_\_\_\_\_

**Employer ph#:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_



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### INSURANCE INFORMATION

Person responsible for the bill:

Birth date:

Address (if different):

Home phone no:

Please indicate primary insurance: \_\_\_\_\_

**If we copied your card, please only indicate the subscriber below (self, partner, parent, etc). If we do not have a copy, please fill out the Insurance information in the sections provided.**

#### Subscriber's name:

(If patient is subscriber, put "self")

SSN (If Tricare)

Birth date:

Group #:

ID #:

Specialist  
Co-payment  
\$ \_\_\_\_\_

Patient's relationship to subscriber:

| Other:

Name of secondary insurance (if applicable):

Subscriber's name:

Group #:

ID #:

Patient's relationship to subscriber:

| Other:

### IN CASE OF EMERGENCY

Name of local friend or relative:

Relationship to patient:

Home phone #:

Work phone #:

### ADVANCE DIRECTIVE

**Do you have an 'Advance Directive'(living will)?**

Yes, it is filed with the Vermont Advance Directive Registry

Yes, it is filed with my primary care provider (PCP)

Yes, it is filed with : \_\_\_\_\_

No, but I would like more information on how to file an 'Advance Directive'.

No, I'm not interested at this time

### ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Maitri Health Care for Women or the insurance company to release any information required to process my claims.

\_\_\_\_\_  
Patient/Guardian signature

\_\_\_\_\_  
Date



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## **Patient Consent for Use & Disclosure of Protected Health Information**

I hereby give my consent for Maitri to access, use, and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Maitri's notice of Privacy Practices provides a more complete description of such uses and disclosures. This includes accessing records from other medical organizations, such as UVM Medical Center.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Maitri reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Maitri Privacy Officer at 185 Tilley Drive, South Burlington, VT 05403.

With this consent, Maitri may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including lab results, among others.

With this consent, Maitri may mail to my home or alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Maitri restrict how it uses or discloses my PHI to carry out treatment, payment, or health care operations. However, the practice is not required to agree to the requested restrictions, but if it does agree, it is bound by this agreement.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

By signing this form, I am consenting to Maitri's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my previous consent.

Signature of patient or legal guardian: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Date: \_\_\_\_\_



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## Payment Policy

Thank you for choosing us as your obstetrics and gynecology provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Maitri participates in or has contracts with many insurance companies. If you have one of the contracted insurances, we accept the amount they allow for services rendered. Please be aware that you are still responsible for any deductibles, non-covered services determined by your insurance carrier to not be medically necessary, or for any balances that remain. If payment is not received from your insurance company within 45 days from the billing date, we may request your assistance in working with your insurance company. Please be aware that the balance of your claim is your responsibility, whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract. Although we may be contracted with your insurance carrier, our services may not be covered by your particular plan, and we highly recommend that you contact your insurance carrier to verify coverage for the services we offer.

If you do not have insurance, you are responsible for payment of your bill, in total, at the time of your visit. We accept personal checks, cash, MasterCard, Visa, and Discover Card. Maitri Health Care for Women will arrange a payment plan for you if necessary at the time of your visit.

If you are a custodial parent, by law you are ultimately responsible for payment of your child's medical bills, even if you are not the carrier of your child's insurance policy. Our agreement to care for your child is made with you.

Should there be an outstanding balance due to Maitri Health Care for Women for services received, and we see no effort has been made to contact us to arrange payment, **Maitri Health Care for Women reserves the right not to schedule further appointments until your outstanding bill has been paid in full.**

If you have applied for Medicaid and are awaiting approval, you will be responsible for the amount due at the time of each office visit until you have been approved for Medicaid insurance. We accept personal checks, cash, MasterCard, Visa, and Discover Card. Maitri Health Care for Women will arrange a payment plan for you if necessary at the time of your visit.

## Cancellation/No-show Policy

We are committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. Please call us @ 802-862-7338, option 3 by 24 hours before your appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call us by 2 p.m. on Friday. If prior notification isn't given, your account will be charged \$75.00

**I have read, understand, and agree to abide by these guidelines.**

Patient or Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Printed Name: \_\_\_\_\_



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**FAX: 802-861-4236** P: 802-862-7338  
185 Tilley Drive, So Burlington, VT 05403

**Authorization to Release Protected Health Information (PHI):**

Patient Full Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Current Address/City/State/Zip: \_\_\_\_\_

List any previous names: \_\_\_\_\_ Phone: \_\_\_\_\_

I authorize the use and disclosure of my health information as described below, **limited to one form per provider/facility:**

- I permit Maitri to OBTAIN my medical records **FROM:**
- I permit Maitri to RELEASE my medical records **TO:**

**Facility/Provider Name:**

\_\_\_\_\_

**City/State:**

\_\_\_\_\_

**Phone:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**Reason for Transfer of Records (circle one):** Coordination of care |  Transfer of Care |  Personal Record

Other, List: \_\_\_\_\_

- I permit the receiving persons/organizations to send health information back to the providing persons/organizations (as in coordination of care).

I would like to release the following information (**circle one**):  Entire Medical Record

Medical Record for the last 2 years |  Other (list specific records and/or date range):

Restrictions: Do not release (specify records to exclude from release):

**PLEASE SIGN ON THE BACK**



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### **CONDITIONS OF AUTHORIZATION:**

I understand that:

- If I refuse to release all or some of my health information, it may result in improper diagnosis or treatment, denial of coverage, a claim for health benefits, or other insurance of other adverse consequences.
- The information to be released may include information related to Hepatitis, sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), genetic testing, behavioral or mental health services, and treatment of alcohol or drug abuse.
- I may be charged a fee for copies of records in accordance with state and federal law. There is no fee for records faxed directly to another provider.
- I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing, and my revocation will not apply to the information that has already been released in response to this authorization.
- Information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected under federal and state law.
- Signing this form is voluntary. I do not need to sign this form to receive health care services at Maitri Healthcare.
- This authorization will expire on \_\_\_\_\_. If I do not specify an expiration date, this authorization will expire one year from the date of signature.

PRINTED NAME: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_