ORCHARD MEDICAL GROUP
FAMILY MEDICINE

Consent for Communication via Phone, Email, or Text Messaging

I, (Patient Name) _____ Date of Birth (DOB): _____ authorize Orchard Medical Group to communicate with me electronically or by cell phone, as set forth in this form.

We at Orchard Medical Group value clear and timely communication with our patients. By providing consent, you or your legal guardian authorize us to contact you regarding your healthcare and outstanding balances via phone, email, or text messaging (SMS). Below are the terms and conditions of this consent:

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1. Purpose of Communication

We may use phone, email, or text messaging to communicate about:

- Appointment reminders
- Billing inquiries and outstanding balances
- Prescription refills
- Lab and test results
- Referral updates
- Other general medical and business matters

By providing your contact details, you agree to receive such communications.

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2. Risks of Using Email and Text Messaging

While we strive to protect your privacy, electronic communications carry certain risks:

- Messages may be misaddressed or intercepted.
- E-mails and texts can be forwarded, stored, or printed.
- Sensitive information may inadvertently be accessed by others (e.g., employer systems or shared devices).
- Unauthorized parties could access or alter communications.
- Deleted messages may still be recoverable from devices.

Please be cautious when providing contact details and ensure your devices are secure.

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3. Consent for Billing-Related Communications

We may contact you via phone, email, or SMS regarding outstanding balances or billing-related matters. By consenting, you authorize the use of automated dialing systems, pre-recorded messages, or direct communication to reach you.

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4. Conditions for Communication

- **Medical Records Inclusion:** Communications may be included in your medical record.
- **Response Times**: Responses to emails or texts may take longer. Do not use these methods for emergencies or urgent medical needs.
- **Sensitive Topics**: For privacy, avoid discussing sensitive topics (e.g., mental health, STDs, or HIV) via email or text.
- **Patient Responsibility**: If you don't receive a response, follow up by phone.

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5. Your Rights and Responsibilities

- Providing consent is voluntary and will not affect your care.
- You may withdraw your consent at any time by submitting a written request. Please allow 30 days for processing.
- Inform us promptly if your contact details change.
- Do not use employer systems for communication to ensure confidentiality.

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6. Acknowledgment and Agreement

By signing this form, you acknowledge that you have read and understand the risks and conditions outlined. You agree to the use of phone, email, and SMS for communications, including billing-related inquiries.

Contact Preferences

Please provide your preferred contact information:

- **Cell Phone (Voice or Text)**: _____
- **Email**: _____

Patient/Guardian Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

For questions about this consent, please contact Orchard Medical Group at (603) 329-5222.

ORCHARD MEDICAL GROUP
FAMILY MEDICINE

AUTHORIZATION TO REQUEST PROTECTED HEALTH INFORMATION

I authorize the following individual or entity to release the protected health information of the patient named below. I acknowledge that any information disclosed under this authorization may be subject to redisclosure by the recipient, unless otherwise restricted by law.

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City/Town:** _____

State: _____ **Zip Code:** _____ **Phone:** _____

Name of facility or person that now holds the records:

Facility Name: _____

Address: _____ **City:** _____ **State:** _____

Zip Code: _____ **Phone:** _____ **Fax:** _____

➢ **PLEASE TRANSFER RECORDS TO:** **ORCHARD MEDICAL GROUP**

____ **SALEM OFFICE**
159 N. Broadway, Salem, NH 03079
Phone: (603) 893-4119
Fax: (888) 927-0461

_____ **HAMPSTEAD OFFICE**
207 Stage Road, Hampstead, NH 03481
Phone: (603) 893-4119
Fax: (888) 927-0461

REPORTS REQUESTED:
HISTORY AND PHYSICAL _____ **OFFICE NOTES** _____
XRAY / IMAGING REPORTS _____ **OTHER** _____
LAB/PATHOLOGY _____
ALL OF THE ABOVE ___✓___

HIGHLY CONFIDENTIAL INFOMATION:
MENTAL HEALTH _____ **ALCOHOL/DRUG USE** _____
HIV/AIDS _____ **SEXUALLY TRANSMITTED DISEASE** _____
OTHER _____
ALL OF THE ABOVE ___✓___

PURPOSE OF DISCLOSURE: MEDICAL CARE ___✓___ **OTHER** _____

➢ **Note: This request will expire six months from the request date, unless otherwise noted.**

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
Name of Legal Representative **Relationship to Patient**

ORCHARD MEDICAL GROUP
FAMILY MEDICINE

Authorization to Share or Discuss Patient Information

I, _____DOB: _____/_____/_____
authorize Orchard Medical Group to share and discuss my medical care and treatment details with the person(s) listed below while I am under the care of Orchard Medical Group or hospitalized.

This authorization will remain in effect until I provide written notice of revocation.

Authorized Individual(s) for Information Sharing

Name: _____

Relationship: _____

Telephone Number: _____

Name: _____

Relationship: _____

Telephone Number: _____

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

159 N. BROADWAY, SALEM, NH 03079
Tel # (603) 893.4119/ Fax # (888) 927.0461

207 STAGE ROAD, HAMPSTEAD, NH 03841
Tel # (603) 329.5222/ Fax # (888) 927.0461

ORCHARD MEDICAL GROUP
FAMILY MEDICINE

Insurance Waiver and Financial Responsibility Agreement

To ensure your care is covered by your insurance plan, it is essential to designate a Primary Care Provider (PCP) within Orchard Medical Group if required by your insurance. This designation allows you to receive care from any provider at our Salem and Hampstead locations. Please review the agreement below carefully to understand your responsibilities regarding PCP selection and associated financial obligations.

PCP Selection Requirement:

I understand that if my insurance plan requires a designated Primary Care Provider (PCP), I must select a PCP within Orchard Medical Group. This selection ensures my access to care at both the Salem and Hampstead offices. I acknowledge that failure to update my PCP designation with my insurance provider may result in denied coverage for my visits. In such cases, I agree to accept full financial responsibility for any charges incurred.

Available Providers for PCP Selection:
The following providers are available for PCP designation within Orchard Medical Group:

- **Alan M. Stein, MD** | NPI 1740279256
- **Audrey Morgan, FNP-BC, APRN** | NPI 1124403332
- **Kathleen Devejian, FNP-BC, APRN** | NPI 1528579257
- **Lindsay Jones, FNP-BC, APRN** | NPI 1528579257
- **Krimish Bhagat, PA-C, MPAS** | NPI 1760001770

By signing this agreement, I confirm that I have read, understood, and agree to the requirements outlined above. I further acknowledge and accept financial responsibility for any charges not covered by my insurance due to my failure to select a PCP within Orchard Medical Group.

Printed Name: _____ DOB: _____

Signature: _____
(Patient or Parent/Legal Guardian, if patient is a minor)

Relationship to patient: _____ Date: _____

Important: Please choose a PCP from the list above and promptly notify your insurance provider of your selection to avoid disruptions in coverage or unexpected out-of-pocket expenses.

Thank you for entrusting your care to Orchard Medical Group. We are committed to providing you with the highest quality care.

159 N. BROADWAY, SALEM, NH 03079
Tel # (603) 893.4119/ Fax # (888) 927.0461

207 STAGE ROAD, HAMPSTEAD, NH 03841
Tel # (603) 329.5222/ Fax # (888) 927.0461

*FORM UPDATED: **1/2025***

ORCHARD MEDICAL GROUP

PATIENT REGISTRATION FORM

Today's Date_____

Name: _____ Maiden Name: _____

Date of Birth: _____/_____ /_____ Marital Status: S M W D

Address:_____ City _____State _____ Zip Code_____

Home Telephone: _____Cell #_____Work # _____

Social Security # _____ - _____ - _____

E-Mail Address _____
Do you wish to join our Patient Portal to view medical records and receive appointment reminders? **YES / NO**

PRIMARY INSURANCE: _____

ID#_____ Group # _____

Subscriber's Name _____ DOB: _____

SECONDARY INSURANCE: _____ _____ ID# _____

PHARMACY - Local Name _____Address: _____

Mail Away (If applicable) _____ **PREFERRED LAB:**_____

CONSENT TO DISCUSS - May we share your healthcare with anyone other than yourself? YES / NO

Name of Recipient: _____Relationship: _____

PRIMARY LANGUAGE: _____ Decline to Answer: _____ ETHNICITY _____ Decline to Answer: _____

RACE: Caucasian ____ American Indian/Alaska Native ____ Asian____ Hispanic/Latino ____
Black/African American ____Native Hawaiian____ Other _____ Decline to Answer ____

EMERGENCY CONTACT:

NAME: _____ Relationship:_____

Home Telephone # _____ Work/Cell# _____

Information regarding the Health Insurance Portability & Accountability Act of 1996 (HIPAA) given upon request.

_____ _____

Signature Date

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION

1, the undersigned, certify that I (or my dependent) have insurance coverage with _____and assign directly to Orchard all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance admissions.

_____ _____

Signature Date

~ ORCHARD MEDICAL GROUP ~

NEW PATIENT - MEDICAL HISTORY FORM

DATE: _____/_____/_____

Name: _____ Age _____ Birthdate ____/____/____

Address: _____ Sex: ◯ M ◯ F

_____ Home Phone: _____

_____ Work Phone: _____

Occupation: _____ Emergency Contact: _____

◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

If married, spouse's name _____

Children's names and ages _____

ALLERGIES TO MEDICATIONS, X-RAY DYES OR OTHER SUBSTANCES NO _____ YES _____

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation:_____Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

FAMILY MEDICAL HISTORY

_____ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer *(Type:*	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other_____	Other_____	Other_____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other:_____																		

SOCIAL HISTORY

Occupation *(or prior occupation)*:	_____ Retired _____ Unemployed _____ Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: Single _____Partner _____ Married _____Divorced _____Widowed _____ Other:_____	
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day_____# of Years _____	***Past:*** Quit Date:_____Packs/day_____# of Years _____		
Other Tobacco *(check one)*: ____ Pipe ____ Cigar ____ Snuff ____ Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	Beer / Wine / Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N		Have you ever used needles to inject drugs? Y N	
Have you ever taken someone else's drugs? Y N			

OTHER HEALTH ISSUES continued...

SEXUAL ACTIVITY	Sexually involved currently? Y N *If no sexual history, please continue to Exercise)*	
Sexual partner(s) is/are/have been: o Male o Female		
Birth control method: _____None _____ Condom _____Pill/Ring/Patch/Injection/IUD _____Vasectomy		
EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*	
What kind of exercise?	***Duration:*** How long (min.):_____How often: _____	
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?	
DIET	How would you rate your diet? Good / Fair / Poor	Would you like advice on your diet? Y N
SAFETY	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N
Working smoke detector in home? Y N		If you have guns at home, are they locked up? Y N
Is violence at home a concern for you? Y N		Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		
Other:_____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

REVIEW OF SYSTEMS ✓ CHECK ALL THAT APPLY

CONSTITUTION	CARDIOVASCULAR	SKIN
Activity change	Chest pain	Color change
Appetite change	Leg swelling	Pallor
Chills	Palpitations	Rash
Diaphoresis	**GASTRO-INTESTINAL**	Wound
Fatigue	Abdominal distention	**ALLERGY/IMMUNO**
Fever	Abdominal pain	Environmental Allergies
Unexpected weight change	Anal bleeding	Food allergies
HEAD, EAR, NOSE & THROAT	Blood in stool	Immunocompromised
Congestion	Constipation	**NEUROLOGICAL**
Dental problem	Diarrhea	Dizziness
Drooling	Nausea	Facial asymmetry
Ear discharge	Rectal pain	Headaches
Ear pain	Vomiting	Light-headedness
Facial swelling	**ENDOCRINE**	Numbness
Hearing loss	Cold intolerance	Seizures
Mouth sores	Heat intolerance	Speech difficulty
Nosebleeds	Polydipsia	Syncope
Postnasal drip	Polyphagia	Tremors
Rhinorrhea	Polyuria	Weakness
Sinus pressure	**Genitourinary**	**HEMATOLOGIC**
Sneezing	Difficulty urinating	Adenopathy
Sore throat	Dysuria	Bruises/bleeds easily
Tinnitus	Enuresis	**PSYCHIATRIC**
Trouble swallowing	Flank pain	Agitation
Voice change	Frequency	Behavior problem
EYES	Genital sore	Confusion
Eye discharge	Hematuria	Decreased concentration
Eye itching	Penile discharge	Dysphoric mood
Eye pain	Penile pain	Hallucinations
Eye redness	Penile swelling	Hyperactive
Photophobia	Scrotal swelling	Nervous/anxious
Visual disturbance	Testicular pain	Self-injury
RESPIRATORY	Urgency	Sleep disturbance
Apnea	Urine decreased	Suicidal ideas
Chest tightness	**MUSCULAR**	
Choking	Arthralgias	
Cough	Back pain	
Shortness of breath	Gait problems	
Stridor	Joint swelling	
Wheezing	Myalgias	
	Neck pain	
	Neck stiffness	

ORCHARD MEDICAL GROUP
FAMILY MEDICINE

Notice of Privacy Practices Health Insurance Portability and Accountability Act of 1996

Your Privacy, Our Priority

This notice describes how your medical information may be used and disclosed, and how you can access this information. Please review it carefully.

Our Facilities

Hampstead Office
207 Stage Road
Hampstead, NH 03841
Tel: (603) 329-5222
Fax: (888) 927-0461

Salem Office
159 N. Broadway
Salem, NH 03079
Tel: (603) 893-4119
Fax: (888) 927-0461

www.OrchardMedGroup.com

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.

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider, a record of your care is created. Typically, this record contains medical information such as your symptoms, examination, test results, diagnoses, treatment and/or treatment plan, and billing-related information. This information is considered protected health information (PHI).

This Notice is intended to advise you about the ways we may use and disclose medical information about you. It also describes your rights and certain obligations with regard to your medical information and applies to all the records of your care generated by your healthcare provider(s) for our organization.

Our Responsibilities

Orchard Medical Group is required to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information that we collect and maintain.

We are required by law to abide by the terms of this Notice and notify you if changes are made. We reserve the right to make changes to the Notice and make the new provisions effective for all protected health information we maintain. Copies of our Notice are available in our main reception area(s) and on our website.

About You

The following describes examples of the way we may use and disclose medical information:

For Treatment:
We may use medical information about you to provide, coordinate, and manage your treatment or services. We may disclose medical information about you to other healthcare professionals such as physicians, nurses, technicians, clinical laboratories, imaging centers, medical students, or other personnel who are involved in your care.

We may communicate your information using various methods, including orally, written, facsimile, and electronic communications.

We may also provide other healthcare professionals who contribute to your care with copies of various reports and information to assist them and ensure that they have appropriate information regarding your condition, treatment plan, and diagnosis.

For Payment:
We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. Examples may include contacting your insurance company for referrals, verification, or preapproval of covered services.

Communication About Billing & Outstanding Balances:
We may contact patients via phone, e-mail, or text messaging (SMS) regarding outstanding balances. By providing consent, patients and guardians agree to receive these billing-related communications as outlined in the Patient/Health Care Provider E-Mail/Texting Consent form. To opt out, contact our office or reply "STOP" to the text messages.

For Health Care Operations:
We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to, quality assessments, employee review activities, licensing, legal advice, accounting support, information systems support, and conducting or arranging for other business activities. We may contact you to remind you of your appointment by telephone or reminder card unless requested otherwise.

Business Associates:
Business Associates (BA) provide services for our organization through written contracts and/or service agreements. Examples of these services include billing and collection and software support. We may disclose your health information to a BA so they can perform the services we have asked them to do, such as billing your third-party payer for services rendered. The BA is also required by law to protect and safeguard your health information, which is clearly defined through our Business Associate Agreement and written contracts/service agreements.

Breach Notification:
In the event that there has been a breach of unsecured protected health information (PHI) identified on behalf of our organization or a BA, you will be notified within 60 days of the breach. In addition to your individual notification, we may be required to meet further reporting requirements set forth by state and federal agencies.

Uses and Disclosures That May Be Made With Your Consent, Authorization, or Opportunity to Object

We will not use and disclose information without your written authorization, except as described in this Notice or as required by applicable laws. Written authorization is required for most uses and disclosures of psychotherapy notes; PHI for marketing purposes unless we speak with you; and disclosures that constitute a sale of PHI.

If you provide an authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your authorization.

Individuals Involved in Your Care or Payment for Your Care
Unless you object, we may release medical information about you

to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

Future Communications
Future Communications: We may communicate with you via newsletters, mailings or other means regarding treatment options and information on health-related benefits or services; to remind you that you have an appointment; or other community-based initiatives or activities to include limited marketing or fundraising initiatives in which our facility is participating. You have the right to opt out at any time if you are not interested in receiving these communications, please contact our Privacy Officer.

Marketing and fundraising initiatives, if applicable, are limited and may require separate authorization.

Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object
We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

As Required by Law: We may use and disclose health information to the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury, or disability
- Correctional Institutions
- Workers' Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners, and Medical Examiners
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authorities that Receive Reports on Abuse and Neglect

If you are not present, able to agree, or object to the use or disclosure (such as in an emergency situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the information relevant to your health care will be disclosed.

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

State-Specific Requirements: Many states have reporting requirements that may include population-based activities related to improving health or reducing health care costs, cancer registries, birth defect registries, and others.

Your Health Information Rights
Although your health record is the physical property of the practice that compiled it, you have the right to:

Inspect and Copy: You and/or your personal representative have the right to inspect, review, and receive a copy of your medical information. Electronic copies are available and may include various electronic means such as a patient portal or other reasonable accommodations requested. We may deny your request to inspect and copy in limited circumstances, including the release of psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. If you are denied access to medical information, you may request that the denial be reviewed.

Requests to copy and/or review must be submitted in writing to Orchard Medical Group. There will be a fee charged for all applicable copying and producing copies of portable media (CD, USB) up to the maximum amount prescribed by governing law.

Amend: If you feel that the medical information we have is incomplete or incorrect, you may ask us to amend the information by submitting a request in writing.

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of your medical information; the list will not include disclosures to carry out treatment, payment, and healthcare operations. Orchard Medical Group will provide the first accounting to you in any 12-month period without charge, upon receipt of your written request. The cost for subsequent requests for an accounting within the 12-month period will be up to the maximum amount prescribed by governing law.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or healthcare operations *Restrictions from Your Health Plan*: You have the right to request that we restrict disclosure of your medical information to your health plan for covered services, provided the disclosure is not required by other laws. Services must be paid in full by you, out of pocket. *Other Restrictions:* You also have the right to request and limit any medical information we disclose about you to someone who may be involved in your care or the payment of your care, such as a family member or friend. We ask that you submit these requests in writing.

We may not agree or be required to agree to your request(s) for specific reasons. If this occurs, you will be informed of the reason(s) for the denial.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may request that we use an alternate phone number or address. We ask that you submit these requests in writing.

Email communication requests, if applicable, may require a separate authorization.

To Exercise Your Rights:To exercise any of your rights, please submit your request in writing to the practice's Privacy Officer listed below.

For More Information or to Report a Problem
If you have questions and would like additional information, please contact the Privacy Officer. If you believe that your (or someone else's) privacy rights may have been violated, you may file a complaint with the Privacy Officer at the contact number below or with the Secretary of Health and Human Services at 800-368-1019. Further instructions for filing a complaint can also be found at www.hhs.gov/ocr. All complaints must be submitted in writing within 180 days of when you knew that the act or omission occurred, and there will be no retaliation for filing a complaint.

Privacy & Complaince Officer: Nathan Grennon

Telephone Number: 603-457-4115

WWW.ORCHARMEDGROUP.COM