



Instructions for RAHC COVID Testing:

Once we receive your information, it will be entered into our system and a scheduler will contact you for an appointment. If you have not been contacted within 24 hours, please call 540-464-8700 extension 7201.

- Please arrive 5 minutes prior to your appointment.
- Bring a photo id.
- When you arrive, call 540-464-8700 extension 7204 upon arrival, and provide your name and color/type of car.
- A COVID team member will come out to get you or administer the test in your car. You will be asked to present your photo id and verify information on collection tube.
- If a rapid test is ordered, we will take 2 swabs, as our protocol is to send out the PCR if the rapid is negative.
- Once testing samples are obtained, you are asked to leave to free up designated spaces, negative results will be available on the RAHC portal, rapid within 1 hour, PCR within 2-5 days.
- We will contact you via phone with any positive results.



Patient Registration Form

Please call or text (540) 464-8700, or ask a Patient Access Representative for help with filling out forms.

This form registers me for all services. I'm interested in: Medical Dental Behavioral Health Family Planning

Patient's Full Legal Name			
Full Name			
Date of Birth		Social Security Number	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Mailing Address			
City	State	Zip Code	County/City of Residency
Physical Address (if different than mailing)			
House Phone		Cell Phone	Work Phone
If we are unable to contact you and you have voicemail, do we have your permission to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Email address: _____ Patients with email addresses listed on this registration form will automatically be registered with our patient portal which can be accessed by visiting our website www.rockahc.org . You can request medication refills, view lab results and more.			
<i>For minors:</i> Is there a custody order on file? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide a current custody order. Note: a parent or legal guardian must be present at the first visit.			
Employment Information			
Are you employed? <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed		Name of Employer	
Employer Address		City	State Zip Code
Are you a student? <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Not a Student			
Financial Responsibility (For minor patients, it is the parent/legal guardian completing this form.)			
<input type="checkbox"/> Self (Skip to next section if checked here) <input type="checkbox"/> Parent <input type="checkbox"/> Legal Custodian <input type="checkbox"/> Guardian/Power of Attorney			
Last Name		First Name	
Date of Birth		Social Security Number Home Phone	
Address <input type="checkbox"/> Same as above		City	State Zip Code
What is the estimated total annual household income before taxes, including wages and disability? <input type="checkbox"/> Under \$11,000 <input type="checkbox"/> \$15,001- \$20,000 <input type="checkbox"/> \$25,001- \$35,000 <input type="checkbox"/> \$45,001- \$55,000 <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> \$11,001- \$15,000 <input type="checkbox"/> \$20,001- \$25,000 <input type="checkbox"/> \$35,001- \$45,000 <input type="checkbox"/> Over \$55,000			
How many people are living in your home, including yourself? _____			

RAHC offers additional savings based on household size and income to uninsured and insured patients. If the income is under this amount per year before anything is taken out, please complete the **Application for the Sliding Fee Discount**.

1 person= \$25,520 2 people= \$34,480 3 people= \$43,440 4 people= \$52,400 5 people= \$61,360 6 people= \$70,320

**Limits are higher for Family Planning Services*

Pharmacy

Name of Preferred Pharmacy: _____

If left blank, all prescriptions will go to Lexington Prescription Center, where patients receive the biggest discount.

Provider Information

Are you transferring medical care to RAHC?

Yes – From which practice? _____

No – Current Primary Care Provider?

Are you transferring dental care to RAHC?

Yes – From which practice? _____

No – Current Primary Care Provider?

List other health care professionals involved in your care:

Do you have an advanced directive Yes No

If yes, your clinical team would like to have a copy on file.

We have sample advanced directives if you don't have one.

Medical Insurance

Do you have medical insurance Yes No If yes, insurance company name: _____

Plan ID Number

Plan Group Number

Policy Holder Name

Date of Birth

Social Security Number

Policy Holder Address

Phone Number

Do you have secondary health insurance Yes No If yes, insurance company name: _____

Plan ID Number

Plan Group Number

Policy Holder Name

Date of Birth

Social Security Number

Policy Holder Address

Phone Number

Dental Insurance

Do you have dental insurance Yes No If yes, insurance company name: _____

Plan ID Number

Plan Group Number

Policy Holder Name

Date of Birth

Social Security Number

Policy Holder Address

Phone Number

Dental Benefits Phone Number on Card

Additional Patient Information	
We collect information on our patients to help us know more about the community we serve and to improve our services. We report this information without identifying patients personally. <i>For example, we report that we serve 100 veterans.</i>	
Veteran Status: Have you ever been in the Armed Forces of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you active duty military? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ethnicity: <input type="checkbox"/> Hispanic or Latin American <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unreported/refused to report	
Race: <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Other race <input type="checkbox"/> Unreported/refused to report	
Preferred Language: _____ Do you require assistance with language interpretation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sexual Orientation: <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Straight <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know <input type="checkbox"/> Choose Not to Disclose	
Gender Identity : <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male (Female to Male) <input type="checkbox"/> Transgender Female (Male to Female) <input type="checkbox"/> Genderqueer (neither exclusively male or female) <input type="checkbox"/> Choose Not to Disclose <input type="checkbox"/> Other	
Residence: Are you a seasonal resident? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you live in public housing? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a migrant worker? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you living in a multi-family home? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Privacy Information	
Government HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations require permission from the patient in order for any healthcare professional to speak with family, friends or caregivers regarding your protected health information, except in cases of emergency. RAHC is serious about the responsibility of keeping your medical and account information private and confidential. The RAHC's full Notice of Privacy Practices can be viewed online at www.rockahc.org or by requesting a copy at the Front Office.	
In order for us to share any of your information, we must have written permission. We have your permission to talk to the following people about general scheduling, medical, account/financial information.	
Name of Emergency Contact #1	Permission to discuss <input type="checkbox"/> Medical <input type="checkbox"/> Financial
Home or Cell Phone Number	Relationship to Patient
Name of Emergency Contact #2	Permission to discuss <input type="checkbox"/> Medical <input type="checkbox"/> Financial
Home or Cell Phone Number	Relationship to Patient
Signature	
I understand that by signing this document, I attest to the accuracy of the information provided. I also understand that if the information changes, I will contact RAHC. (For minor patients, parent/legal guardian completing this form sign below.)	
Signature	Print Name
Relationship to patient	Date



HIPAA RELEASE OF INFORMATION
Authorization to Use or Disclose Protected Health Information

RAHC Fax Number: (855) 806-0826

Patient Name: _____		
Date of Birth: _____	Age: _____	SSN: _____
Home Phone: _____	Cell Phone: _____	
Address: _____		
City: _____	State: _____	Zip Code: _____

I give permission for RAHC to mail my COVID-19 test results to the address listed in registration:

Yes No

If a copy of results are needed, I will come in at a later time to obtain them:

Yes No

I understand that I have the right to revoke this authorization by submitting my request in writing. I further understand that Rockbridge Area Health Center may re-disclose records received under this authorization, except for mental health records, which require a separate re-disclosure authorization. I also understand that I may refuse to sign this authorization and it is strictly voluntary, but I also understand that certain records are needed for the best quality medical care. I fully understand and accept the terms of this authorization, which shall remain in effect one year from the date of the request unless otherwise stated.

Patient/Legal Guardian Signature

Relationship to Patient

Date



GENERAL CONSENT

1. **CONSENT TO FILE INSURANCE/CORRECT INFORMATION.** I authorize the release of any and all medical information necessary to process my insurance claims. I permit a copy of the authorization to be used in place of the original. I authorize RAHC to file with my insurance for services rendered. I request that payment be made directly to RAHC. I certify that the information that I have reported with regard to my insurance coverage and my personal information is correct. I understand that I am responsible for any and all balances that my insurance company does not pay. I understand that claims may be filed electronically through a secure internet portal.

2. **HIPAA NOTICE OF PRIVACY POLICY.** I acknowledge that I have received and/or have read RAHC's Notice of Privacy Policy Effective June 2, 2014. This document is available on line to review or can be reviewed at our office. If you would like someone to review it with you please let us know.

3. **CONSENT FOR TREATMENT.** I give my consent to the medical staff of RAHC to perform emergency medical treatment, acute or chronic medical treatment, preventive health care, dental care, behavioral/mental health care, and health maintenance care as deemed medically necessary. (If the individual is a minor at the time of consent, a parent or legal guardian must sign this consent for treatment.) There is only one electronic health record used between primary care team members in addressing your treatment plan of care and this health information is shared between these primary care team members. A "Behavioral Health Consultant" is a member of the primary care team that works closely with your medical provider to recognize and address medical conditions associated with acute and chronic mental and emotional disordered conditions.

4. **CONSENT FOR MEDICAL RECORD AND PRESCRIPTION HISTORY.** I give my consent to the medical staff of RAHC to access and use my medical record and prescription history from other healthcare providers or third party pharmacy benefit payors that is available via secure health information exchanges (HIE).

5. **CONSENT TO COMMUNICATE VIA SMS:** I authorize RAHC through its vendors Wellapp and eCW to contact me by SMS text message to serve me better. RAHC may send me text messages to help me or my child stay healthy, including:

- timely reminders about doctor or dental appointment
 - health maintenance reminders
 - information to help manage illnesses
- I understand that message/data rates may apply to messages sent through RAHC to my cell phone and that I may receive up to 10 texts per month.
 - I know that I am under no obligation to authorize RAHC to send me text messages as part of this program.
 - I may opt-out of receiving these communications from RAHC at any time by calling RAHC at 540-464-8700

6. **DEEMED CONSENT FOR DESIGNATED BLOODBORNE PATHOGENS.** Section 32.1-45.1 of the Virginia Code authorizes health care providers to test patients for HIV and Hepatitis B and C if a health care worker is exposed to blood or bodily fluids of the patient in a manner which, according to current guideline of the Center for Disease Control, may transmit HIV or Hepatitis B or C viruses. In the event of such an exposure, I am deemed to have consented to testing and release of results to person(s) exposed. However, I will be counseled before any of my blood is tested for HIV or Hepatitis B or C, as well as afterwards when I receive the results.



GENERAL CONSENT

This consent form will be used as needed. You may revoke or change any of the above consents at any time.

Participation in all of the programs offered at RAHC is voluntary and is not a requirement to receive care.

When signing the electronic signature pad at RAHC before your first visit, you acknowledge:

- 1) review of RAHC's Consent to File Insurance/Correct Information.
- 2) review of RAHC's Notice of Privacy Policy effective June 2, 2014;
- 3) review of RAHC's Consent for Treatment
- 4) review of RAHC's Consent for Medical Record and Prescription History
- 5) review of RAHC's Consent for Text Communication
- 6) review of RAHC's Consent for Bloodborne Pathogens
- 7) review of RAHC's Patient Rights and Responsibilities (registration packet)

Signature of Patient or Patient's Representative

Date