Rockbridge Area
**Health Center**

# Patient Registration Form

**Patient's Full Legal Name**

Full Name

Date of Birth | Social Security Number

Gender ❒ Male ❒ Female ❒ Unknown | Marital Status ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Mailing Address

City | State | Zip Code | County/City of Residency

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? ❒ Yes ❒ 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 access your vaccine record from this portal.

**Additional Information**

**Do you have medical insurance:** ❒ Yes ❒ No

**Primary Medical Insurance:**_____ **Subscriber Name:**_____

**Policy Number:**_____ **Subscriber Date of Birth:** _____

**Group Number:**_____

**Ethnicity:** ❒ Hispanic or Latin American ❒ Non-Hispanic ❒ Unreported/refused to report

**Race:** ❒ Asian ❒ White ❒ Black or African American ❒ Pacific Islander
❒ American Indian or Alaskan Native ❒ Other race ❒ Unreported/refused to report

**Name of Emergency Contact #1** | 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.. (For minor patients, parent/legal guardian completing this form sign below)

Relationship to patient | Date

25 Northridge Lane • Lexington, VA 24450
(540) 464-8700 • www.rockahc.org • *fax*: (855) 806-0826

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## 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 vaccination record to the address listed in registration:

☐ Yes ☐ No

If a copy of my vaccination records 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

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# GENERAL CONSENT

1. 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 online to review or can be reviewed at our office. If you would like someone to review it with you, please let us know.

2. 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.

3. CONSENT TO COMMUNICATE VIA SMS. I authorize RAHC through its texting platform and electronic health record vendor 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

4. 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.

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5. CONSENT FOR VACCINATION. I hereby authorize the administration of the COVID-19 vaccine to myself or to the person named below for whom I am the legal representative.

- I have read or have had explained to me the information contained in the Fact Sheet for Recipients and Caregivers: Emergency Use Authorization (EUA) of COVID 19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19) and understand the risks and benefits of the vaccine and alternatives to the vaccine (that is, not receiving the vaccine or waiting for other versions of the vaccine);
- I have had the opportunity to ask questions about this immunization [and any questions I had about the COVID-19 vaccine have been answered to my satisfaction.
- I believe the benefits outweigh the risks, and I accept full responsibility for any reactions that may result from my receipt of the immunization or the receipt of the immunization by the person named below for whom I am the legal representative.
- I agree that my vaccine-related health information may be required to be or may voluntarily be disclosed to my health care provider, my insurance plan, and state or federal registries or other public health authorities, for purposes of treatment, payment or health care operations. I also agree that the organization providing my vaccine may use and disclose my health information as described in its Notice of Privacy Practices.

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 Notice of Privacy Policy effective June 2, 2014
2) review of RAHC's Consent for Treatment
3) review of RAHC's Consent for Text Communication
4) review of RAHC's Consent for Bloodborne Pathogens
5) review of RAHC's Consent for Vaccination

_____

Signature of Patient or Patient's Representative Date

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