Rockbridge Area
Health Center

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

Last Name First Name Middle Name

Date of Birth Social Security Number

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

Mailing Address

City State Zip Code

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? ❒ 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 request medication refills, view lab results and more.

For minors:

Is there a custody order on file? ❒Yes ❒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? Name of Employer

❒Full-time ❒ Part-time ❒ Self-Employed ❒ Retired ❒Not Employed

Employer Address City State Zip Code

Are you a student? ❒Full-time ❒Part-time ❒Not a Student

Financial Responsibility (For minor patients, it is the parent/legal guardian completing this form.)

❒Self (Skip to next section if checked here) ❒Parent ❒Legal Custodian ❒Guardian/Power of Attorney

Last Name First Name

Date of Birth Social Security Number Home Phone

Address ❒Same as above City State Zip Code

What is the estimated total annual household income before taxes, including wages and disability?

❒Under $11,000 ❒ $15,001- $20,000 ❒ $25,001- $35,000 ❒ $45,001- $55,000 ❒ Choose not to disclose

❒ $11,001- $15,000 ❒ $20,001- $25,000 ❒ $35,001- $45,000 ❒ 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= $24,280 2 people= $32,920 3 people= $41,560 4 people= $50,200 5 people= $58,840 6 people= $67,480
**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 ❒ No If yes, from which practice?

Are you transferring dental care to RAHC? ❒ Yes ❒ No If yes, from which practice?

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. *For example, we report that we serve 100 veterans.*

Veteran Status: Have you ever been in the Armed Forces of the United States? ❒ Yes ❒ No
Are you active duty military? ❒ Yes ❒ No

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

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

Preferred Language: _____ Do you require assistance with language interpretation? ❒Yes ❒No

Sexual Orientation:
❒Lesbian or Gay ❒Straight ❒Bisexual ❒Something else ❒ Don't know ❒ Choose Not to Disclose

Gender Identity :
❒Male ❒Female ❒Transgender Male (Female to Male) ❒Transgender Female (Male to Female)
❒ Genderqueer (neither exclusively male or female) ❒ Choose Not to Disclose ❒ Other

Residence: Are you a seasonal resident? ❒ Yes ❒ No
Are you a migrant worker? ❒ Yes ❒ No
Do you live in public housing? ❒ Yes ❒ No
Are you homeless? ❒ Yes ❒ No
Are you living in a multi-family home? ❒ Yes ❒ 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 ❒ Medical ❒ Financial

Home or Cell Phone Number Relationship to Patient

Name of Emergency Contact #2 Permission to discuss ❒ Medical ❒ 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

Rockbridge Area
Health Center

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: _____

I give permission to the Rockbridge Area Health Center to use and *(choose one)*:

☐ Send my RAHC records to ☐ Receive my records from

_____ _____

Name of Facility or Person Phone Number/ Fax Number

_____

Street address City State Zip Code

Dates ranging from _____ to _____

If no date has been specified, only provide the last 2 years

I am requesting the following documentation to be released: (check all that apply)

☐	All Records	☐	Physical Therapy Notes	☐	Physician Office Notes	☐	EKG Reports
☐	Lab Results	☐	Immunization Record	☐	Pharmacy Records	☐	Substance Use Disorder
☐	X-Ray Results	☐	Mental Health Record	☐	HIV/AIDS Info	☐	Other:

The purpose for the release of information at the request of the individual is: (check one)

☐	Transfer of Care*	☐	Disability	☐	Self/Personal Copy	☐	Other:
☐	Insurance	☐	Workman's Comp	☐	Attorney	☐	

***If Transfer of Care is checked, RAHC will become my Primary Medical Care Provider.**

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

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

Rockbridge Area Health Center

HIPAA-Release of Information Form
For Dental Patients Only
Authorization to Use or Disclose Protected Health Information

Patient Name: _____

Date of Birth: _____ Age: _____ SSN: _____

Home Phone: _____ Cell Phone: _____

Address: _____

I give permission to the Rockbridge Area Health Center to use and disclose to ☐ Or obtain from ☐

_____ _____
Name of Facility or Person Phone Number/ Fax Number

_____
Street Address City State Zip Code

Dates ranging from _____ to _____
**If no date has been specified, only provide the last 2 years*

I am requesting the following documentation to be released: (**check all that apply**)

	Dental Records		Imaging

The purpose for the release of information at the request of the individual is: (**check one**)

	Transfer or Continuity of Care		Disability
	Insurance		Workman's Comp
	Self/Personal Copy		Other:
	Attorney		

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.**

_____
Patient/Legal Guardian Signature Relationship to Patient Date

This authorization shall remain in effect one year from the date of the request unless otherwise stated. **Please email x-rays to dentalxray@rockahc.org**

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

Rockbridge Area
Health Center

PATIENT RIGHTS AND RESPONSIBILITIES

You have the RIGHT…

- To choose Rockbridge Area Health Center as your family health care home;
- To be treated with respect and dignity regardless of race, color, sex, religion, sexual preference, national origin, handicap or source of payment;
- To expect quality care which takes into consideration your personal, spiritual, and cultural values;
- To receive confidential treatment;
- To have access to free interpretive services if you do not speak English;
- To access any information contained in your medical record;
- To expect that our health care providers and staff will listen to your needs;
- To receive helpful and understandable information about your diagnosis, treatment, and prognosis;
- To give informed consent before the start of a procedure or treatment;
- To refuse treatment and to be informed of the medical consequences;
- To expect an appointment within a reasonable time frame;
- To know the costs of all procedures and services;
- To receive and understand the statement of fees for services provided;
- To report any concerns about the care you have received and to expect a response to that concern.

You have the RESPONSIBILITY…

- To keep your appointments or to notify the Center promptly if you need to cancel so that others may be seen in your place;
- To tell the health care provider accurate and complete information concerning your present complaints/symptoms, past illnesses/ailments, medications, and any other matters relating to your health;
- To follow the treatment plan recommended by your health care provider;
- To tell the provider if you do not understand the treatment plan and what is expected of you;
- To promptly notify the Center of any changes in your personal information (address, phone numbers, insurance, employment, and other income etc.);
- To pay for services provided or to make arrangements to pay;
- To be respectful toward other patients and staff;
- To help the Center maintain a safe, clean, and comfortable office environment at all times by keeping voices low, silencing cell phone ringers, consuming all food and beverages before entering the center, and attending to small children
- To inform staff of any legal-medical information, such as Powers of Attorney, that might impact decisions about your health care.

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