Rockbridge Area
Health Center

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 or text 540-464-8700.

- Please arrive 5 minutes prior to your appointment.
- Bring a photo id.
- Bring your Health Insurance Card

IF TESTING FOR PROCEDURES OR TRAVEL:

- Enter through the main entrance and check in with our Patient Access Team

IF YOU ARE SYMPTOMATIC:

- When you arrive, call 540-464-8700 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.
- Once PCR testing samples are obtained, you are asked to leave to free up designated spaces.

- Negative results will be available on the RAHC portal within 2-3 business days.
- We will contact you via phone with any positive results.

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

Rockbridge Area
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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 ❒ Male ❒ Female ❒ Unknown Marital Status ❒ Single ❒ Married ❒ Divorced ❒ 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? ❒ 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= $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. *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

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

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: _____

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

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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.

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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

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