



**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

<b>Patient's Full Legal Name</b>			
Full Name			
Date of Birth		Social Security Number	
Gender Assigned at Birth: <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 <a href="http://www.rockahc.org">www.rockahc.org</a> . 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 <b>must</b> be present at the first visit.			
<b>Employment Information</b>			
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			
<b>Financial Responsibility</b> (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: _____ <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"/> Other _____ <input type="checkbox"/> Don't know <input type="checkbox"/> Choose Not	
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 <b>HIPAA (Health Insurance Portability and Accountability Act of 1996)</b> 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 <a href="http://www.rockahc.org">www.rockahc.org</a> 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 <b>general scheduling, medical, account/financial information.</b>	
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: _____	

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)

<input type="checkbox"/>	All Records	<input type="checkbox"/>	Physical Therapy Notes	<input type="checkbox"/>	Physician Office Notes	<input type="checkbox"/>	EKG Reports
<input type="checkbox"/>	Lab Results	<input type="checkbox"/>	Immunization Record	<input type="checkbox"/>	Pharmacy Records	<input type="checkbox"/>	Substance Use Disorder
<input type="checkbox"/>	X-Ray Results	<input type="checkbox"/>	Mental Health Record	<input type="checkbox"/>	HIV/AIDS Info	<input type="checkbox"/>	Other:

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

<input type="checkbox"/>	Transfer of Care*	<input type="checkbox"/>	Disability	<input type="checkbox"/>	Self/Personal Copy	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Insurance	<input type="checkbox"/>	Workman's Comp	<input type="checkbox"/>	Attorney	<input type="checkbox"/>	

**\*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



**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
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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**



## **INSTRUCTIONS- APPLICATION FOR SLIDING FEE DISCOUNT PROGRAM**

The Rockbridge Area Health Center offers a Sliding Fee Discount Program (SFDP) to insured, uninsured and underinsured patients based on annual income and family size under the U.S. Department of Health and Human Services annual Federal Poverty guidelines. RAHC does not discriminate with regard to race, color, religion, national origin, age, gender, sexual orientation or disability. No one will be denied access to services due to inability to pay.

Please fill out the application completely and submit proof of household income along with the completed application. The patient/responsible person must complete the SFDP application in its entirety. Incomplete applications and applications missing income documentation will be returned and significantly delay processing. Patient eligibility for the SFDP is renewed at least once a year and every 6 months for patients with no income.

### **INCOME:**

Income and required proof are defined as:

\*Wages, salaries and tips:

- **One month's worth of pay stubs** that show gross amount (before taxes are taken out)
- RAHC Income Verification Statement to be completed by the employer
- Prior year's Federal Income Tax return (IRS 1040)

\*Self-Employment income: Prior year's Federal Income Tax return (IRS 1040) to determine net income

\*Unemployment compensation: Determination letter

\*Social Security Benefits: **Current year** awards letter listing monthly amount before deductions

\*Alimony: Legal proof or official awards letter

\*Retirement or pension income, including IRA or 401k withdrawals: Bank statements

\*Investment income, like dividends or interest: Monthly statement or awards letter

\*Workers compensation: Determination letter

\*Rental income: copy of a lease or rental payment

\*Other taxable income such as prizes, awards and gambling winnings

**If no income:** a RAHC Statement of Support form must be signed by the patient and the person providing financial support

We count the following for enabling services only: child support, earned income from minor children, Supplemental Security Income, Supplemental Nutrition Assistance Program (SNAP) benefits, Veteran's Disability payments or proceeds from loans (student loans, home equity loans or bank loans)

### **HOUSEHOLD**

Household is defined as: One person or a group of two people or more related by birth, legal marriage/partnership, or adoption and residing together. This excludes persons who may live under the same roof but who do not depend on the patient financially or do not support the patient financially such as roommates or other non-relatives.

Other Adults in home: If you are a spouse in the home, proof of your income is also required. Dependent adult children must provide proof of dependence (IRS 1040).

**Comments: Please use this area to explain any unusual circumstances which you feel may be helpful:**



**APPLICATION FOR SLIDING FEE DISCOUNT PROGRAM**

Legal Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address (if different than mailing): \_\_\_\_\_

Email Address: \_\_\_\_\_ @ \_\_\_\_\_

Telephone #: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Marital Status  Single  Married  Divorced  Widowed

List any full time students in the home: \_\_\_\_\_

List any changes to Insurance: \_\_\_\_\_

List of Family/Household members: If more space is needed, attach a separate sheet	Date Of Birth	Relation To Applicant	Insured Yes or No	List Income Type Wages, unemployment, pension, Social Security, alimony, rental income, investment, other taxable income	Amount Per Month Before Taxes (self-employed net)
		Self			

Number of people living in your household: \_\_\_\_\_ **Monthly Gross Total:**

Applicant's employer: \_\_\_\_\_ Paid How Often? \_\_\_\_\_ Start date: \_\_\_\_\_

Other household member's employer: \_\_\_\_\_ Paid How Often? \_\_\_\_\_ Start date: \_\_\_\_\_

If unemployed, date of last paycheck: \_\_\_\_\_

Please list the monthly amount you receive of:

SNAP Amount \$ _____	Child Support \$ _____	SSI \$ _____	Veteran's Benefits \$ _____	Other: _____
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**DECLARATION:** By signing the SFDP application, the patient/responsible person authorizes the Center to confirm income and family/household size as disclosed on the application. Providing false information on a SFDP application will result in all SFDP discounts being revoked and the full balance of the account(s) restored and payable immediately.

Applicant Signature: _____	Date: _____
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## 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.