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

Full Name

Date of Birth | Social Security Number

Gender Assigned at Birth: ❒ 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

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**

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Rockbridge Area
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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:

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Rockbridge Area
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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 <u>Before</u> Taxes** (self-employed net)
		Self			
					Monthly Gross Total:

Number of people living in your household: _____

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: _____

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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Rockbridge Area
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STATEMENT OF SUPPORT

(This information is required only to determine eligibility for our Sliding Fee Scale Discount Program)

Anyone applying for financial assistance with no source of income must complete this form. It must also be signed by the person providing the financial support and turned in along with the completed financial assistance application. The Statement of Support expires after 6 months after determination of applicant's eligibility for SFDP.

To be completed by the applicant:

I, _____ DOB: _____, declare that I have no employment and do not have income of any kind.

"Family/Household" includes spouse and dependents:

_____

Applicant Signature: _____ Date signed: _____

To be completed by the person(s) providing the financial support:

Name of person(s)/business/organization providing financial assistance (please print):

_____

Relationship to Applicant (if individual): _____

Address: _____State_____ZipCode_____

Phone: _____

Contact Name (if business): _____ Phone Number_____

I verify that the applicant is unable to provide for themselves. I provide support (cash and/or non-cash) to help meet the needs of the applicant (check which applies):

Cash: YES NO Amount paid?_____WEEKLY_____ BI-WEEKLY_____ MONTHLY____

Shelter: YES NO Food: YES NO Clothing: YES NO Transportation: YES NO

I understand Rockbridge Area Health Center may contact me to verify this information. Furthermore, I understand providing false information or information subsequently determined to be false will result in the applicant's eligibility for SFDP discounts to be revoked and the full balance of the account(s) restored and payable immediately.

Signature of person providing financial support:

_____ Date signed: _____

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Rockbridge Area
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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.

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