



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: <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 www.rockahc.org . 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 must be present at the first visit.			
Employment Information			
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			
Financial Responsibility (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 to Disclose	
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 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 <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)**

<input type="checkbox"/> Dental Records	<input type="checkbox"/> Imaging
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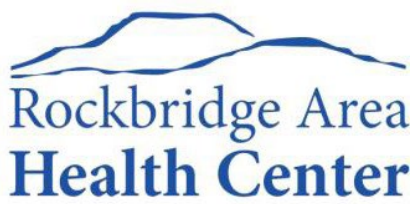
The purpose for the release of information at the request of the individual is: **(check one)**

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

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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**



APPLICATION FOR SLIDING FEE DISCOUNT PROGRAM

Full Name: _____ Social Security Number: _____

Name of Patient (If different from above): _____ DOB: _____

Address: _____ City: _____

State: _____ Zip: _____

Telephone: _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Common Law Marriage

List of Household Members: (Include yourself)	Date Of Birth:	Relation To you:	Insured?	Income Type: Job, unemployment, Social Security, etc	Monthly Income: (before taxes)
		Self			
					Monthly Total:

Employer: _____ Paid How Often? _____ Start date: _____

Spouse's employer: _____ Paid How Often? _____ Start date: _____

If unemployed, date of last paycheck: _____

Please list the amount you receive monthly below:

SNAP Amount \$ _____ Child Support \$ _____ SSI \$ _____ Veteran's Benefits \$ _____ Other _____

By signing below, you give us the right to check your income and household size. If you give false information on this form, your discount will be stopped, and you will have to pay the full balance.

Sign: _____	Date: _____
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INSTRUCTIONS

Please fill out the whole form. You will need to turn in proof of household income and size.

INCOME:

- Pay stubs from the last 30 days or copy of tax return
- Self-Employment
- Unemployment
- Social Security
- Alimony
- Retirement or pension, including IRA or 401k withdrawals.
- Investment income
- Workers' compensation
- Rental income
- Other taxable income, such as lottery winnings

Please call us if you have no income or do not receive pay stubs.

HOUSEHOLD:

A household is you, your spouse, and any children or relatives you claim on your taxes.

Do not include roommates, friends, or anyone you would not claim on your taxes.

The Sliding Fee Discount is based on annual Federal Poverty guidelines.

We do not discriminate against race, color, religion, national origin, age, gender, sexual orientation, or disability.

No one will be denied medical services if they cannot pay.



**Sliding Scale Financial Assistance Program
STATEMENT OF SUPPORT**

Anyone applying for Sliding Scale financial assistance with no income must complete this form.

You will need to reapply after six months.

Name: _____ DOB: _____

Name of Spouse and/or Dependents:

I am not working and do not have income of any kind.

Sign: _____ Date: _____

To be completed by the person or organization giving help.

Name: _____ Relationship: _____

Address: _____ State: _____ Zip Code: _____

Phone: _____ Organization Name: _____

Type of help given: (Please circle)

Cash Amount paid: _____ How Often: _____

Shelter Food Clothing Transportation

I confirm that the person above is not working, and I am helping them. I understand signing this form does **not** make me responsible for their bill. I understand giving false information will cause the discount to stop, and the person above will have to pay the full balance. I understand the Rockbridge Area Health Center may contact me.

Signature of person giving help: _____ Date: _____



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.