



**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:<br><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown  |       | Marital Status:<br><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: _____<br>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><br>Is there a custody order on file? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide a current custody order.<br>Note: a parent or legal guardian <b>must</b> be present at the first visit.  |       |  |                          |
| <b>Employment Information</b>  |       |  |                          |
| Are you employed?<br><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?<br><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<br><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 served in the United States military, armed forces, or uniformed services?<br>This includes: Air Force, Army, Coast Guard, Marines, Navy, Space Force, National Guard, Reserves, or the US Public Health Service and National Oceanic & Atmospheric Association. <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| <b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latin American <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unreported/refused to report<br><b>Race:</b> <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Pacific Islander<br><input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unreported/refused to report  |   |
| <b>Preferred Language:</b> _____ Do you require assistance with language interpretation? <input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| <b>Sexual Orientation:</b><br><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<br><b>Gender Identity :</b><br><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male (Female to Male) <input type="checkbox"/> Transgender Female (Male to Female)<br><input type="checkbox"/> Genderqueer (neither exclusively male or female) <input type="checkbox"/> Choose Not to Disclose <input type="checkbox"/> Other |   |
| <b>Residence:</b> 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<br>Are you a migrant worker? <input type="checkbox"/> Yes <input type="checkbox"/> No                                      Are you homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>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>   |   |
| <b>Name of Emergency Contact #1</b>   | Permission to discuss <input type="checkbox"/> Medical <input type="checkbox"/> Financial |
| Home or Cell Phone Number   | Relationship to Patient   |
| <b>Name of Emergency Contact #2</b>   | 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           |                                 |

**\*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)

Table with 2 columns: Dental Records, Imaging

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

Table with 2 columns: 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



**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:<br>(Include yourself) | Date Of Birth: | Relation To you: | Insured? | Income Type:<br>Job, unemployment,<br>Social Security, etc | Monthly Income:<br>(before taxes) |
|--|----------------|------------------|----------|--|-----------------------------------|
|  |                | Self             |          |  |                                   |
|  |                |                  |          |  |                                   |
|  |                |                  |          |  |                                   |
|  |                |                  |          |  |                                   |
|  |                |                  |          |  |                                   |
|  |                |                  |          |  |                                   |
|  |                |                  |          |  |                                   |
|  |                |                  |          |  |                                   |
| <b>Monthly Total:</b>                            |                |                  |          |  |                                   |

**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:**

|                             |                               |                     |                                    |                    |
|-----------------------------|-------------------------------|---------------------|------------------------------------|--------------------|
| <b>SNAP Amount \$</b> _____ | <b>Child Support \$</b> _____ | <b>SSI \$</b> _____ | <b>Veteran's Benefits \$</b> _____ | <b>Other</b> _____ |
|-----------------------------|-------------------------------|---------------------|------------------------------------|--------------------|

**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.**

|                    |                    |
|--------------------|--------------------|
| <b>Sign:</b> _____ | <b>Date:</b> _____ |
|--------------------|--------------------|



## **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.**

## 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, gender, sexual orientation, gender identity or expression, national origin, age, genetic information, sex, religion, sexual preference, disability, veteran status 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 receive care in a safe setting;
- 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 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 or your experience to the Director of Quality and Compliance of the health center at 540-464-8700 x7198 or via our confidential compliance hotline, at 888-692-6675 or online at [rockahc.i-reported.com](http://rockahc.i-reported.com) and to expect a response to that concern.
- To request and have one staff chaperone in treatment area during time of visit.
- To request Good Faith Estimate (which is only an estimate for the visit).

### 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;
- To follow all infection control guidelines.

If you have any questions about your Rights and Responsibilities as a patient, you can ask your care team or contact RAHC.