Dear New Patient,

Welcome! Thank you for choosing the Rockbridge Area Health Center (RAHC) for your health care needs. RAHC is unique from other local providers because we are able to offer multiple health care services that can improve your physical, dental and emotional well-being. Additionally, we offer medication and financial assistance to qualifying patients, regardless of insurance status.

The forms in this packet include:

Form	Action
Patient Registration- *One per adult*	Return to RAHC
Release of Information	Return to RAHC if a Medical or Behavioral Health patient
Application for Financial Assistance- *One per household*	Return to RAHC
Statement of Support	Return to RAHC
General Consent	For your information
Patient Rights and Responsibilities	For your information
Health Insurance Assistance and Enabling Services	For your information
Medication Assistance	For your information

Completed forms may be mailed to 25 Northridge Lane, Lexington, VA 24450 or delivered Monday through Thursday, 8:00am- 6:00pm and Friday 8:00am- 5:00pm, or faxed to (540) 464-1362.

Our team is available to help answer questions or to meet one-on-one to review the forms and documents. We may be reached at (540) 464-8700, option 1. We strive to process your information within 24 hours and when all processing is completed, we will call to notify you.

Thank you again for choosing RAHC.

Sincerely,

The Outreach and Enrollment Team

Rockbridge Area Health Center

25 Northridge Lane
Lexington, VA 24450
Phone: 540-464-8700
Fax: 540-464-1362
www.rockahc.org

PATIENT REGISTRATION FORM

I am interested in the following services (check all that apply) ❐ Medical ❐ Dental ❐ Behavioral Health

Patient Information

Last Name | First Name | Middle Initial

Date of Birth | Social Security Number

Mailing Address

City | State | Zip Code

Physical Address (if different than mailing)

Home Phone | Cell Phone | Work Phone

Gender ❐ Male ❐ Female | Marital Status ❐ Single ❐ Married ❐ Divorced ❐ Widowed

Email address

How did you hear about us (please check all that apply) ❐ Newspaper ❐ Family/friend ❐ TV ❐ Radio ❐ Facebook ❐ Hospital ❐ Signage on road ❐ Internet search ❐ Insurance company ❐ Other (please specify):

Financial Responsibility of Patient

❐ Self (Skip to next section if checked here) ❐ Parent ❐ Legal Custodian ❐ Guardian/Power of Attorney

Last Name | First Name

Address ❐ Same as above | City | State | Zip Code

Date of Birth | Social Security Number | Home Phone

Employment Information

Are you employed? ❐ Full-time ❐ Part-time ❐ Retired ❐ Not Employed | Name of Employer

Employer Address | City | State | Zip Code

Are you a student? ❐ Full-time ❐ Part-time ❐ Not a Student

Emergency Contact #1

Last Name | First Name

Mailing Address

City | State | Zip Code

Home Phone | Cell Phone | Relationship to Patient

Emergency Contact #2

Last Name | First Name

Mailing Address

City | State | Zip Code

Home Phone | Cell Phone | Relationship to Patient

Pharmacy

Preferred Pharmacy: If left blank, all prescriptions will go to our partner pharmacy, Lexington Prescription Center.

Provider and Insurance Information

If not RAHC, who is your medical primary care physician?

If not RAHC, who is your dental provider?

List other health care professionals involved in your care:

Primary Medical Insurance Company:

Plan ID Number	Plan Group Number
Name of Policy Holder	
Policy Holder's Date of Birth	Policy Holder's Social Security Number

Secondary Medical Insurance Company:

Plan ID Number	Plan Group Number
Name of Policy Holder	
Policy Holder's Date of Birth	Policy Holder's Social Security Number

Primary Dental Insurance Company:

Plan ID Number	Plan Group Number
Name of Policy Holder	
Policy Holder's Date of Birth	Policy Holder's Social Security Number

Do you have an advance directive ❒ Yes ❒ No
If yes, your clinical team would like to have a copy on file. We have sample advance directives if you don't have one.

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.

Ethnicity:
- ❒ Hispanic or Latin American
- ❒ Non-Hispanic
- ❒ Unreported/refused to report

Veteran Status: Have you ever been in the Armed Forces of the United States? ❒ Yes ❒ No
Are you active duty military? ❒ Yes ❒ No

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

Would you like assistance with reading/completing forms?

❒ 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)
❒ Other ❒ Choose Not to Disclose

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

How many people are living in your home, including yourself? __________

What is the estimated total annual household income, including government assistance and disability?

❒ Under $11,000 ❒ $15,001- $20,000 ❒ $25,001- $35,000 ❒ $45,001- $55,000
❒ $11,001- $15,000 ❒ $20,001- $25,000 ❒ $35,001- $45,000 ❒ Over $55,000

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 medical conditions, lab results, test results, treatment results, or appointment information**:

Name	Relationship	Phone
Name	Relationship	Phone

We have your permission to talk to the following people about **account balance and financial information**:

Name	Relationship	Phone
Name	Relationship	Phone

If we are unable to contact you and you have voicemail, do we have your permission to leave a message? ❒ Yes ❒ No

We utilize an automated system for appointment reminders. If you provided a cell phone number, would you prefer your reminder as a: ❒ Phone call ❒ Text message

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. Our patient portal is a way to provide patients with easy access to our services. You can request refills, review your lab results, display/print visit summaries, patient education and immunization records, as well as make payments.

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.

Patient Signature	Date
Parent/Guardian Signature	Date

Rockbridge Area Health Center

25 Northridge Lane
Lexington, VA 24450
Phone: 540-464-8700
Fax: 540-464-1362
www.rockahc.org

Medical and Behavioral Health patients only:

HIPAA RELEASE OF INFORMATION FORM

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 *(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		Other:
	X-Ray Results		Mental Health Record		HIV/AIDS Info		

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.

____
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.

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Phone: 540-464-8700
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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:** _____________________

List any full time students in the home: ____________________________________

"Family/Household" includes the applicant, spouse and dependents.
Please see the back of this form for the definition of family/household and the types of income that must be reported

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: _______________________

If your income is zero, the STATEMENT OF SUPPORT must completed by the person supporting you financially.

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:
Other adult and/or Partner Signature:	Date:

APPLICATION FOR SLIDING FEE DISCOUNT PROGRAM

INSTRUCTIONS

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

*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. Please sign this application if you live in the home and wish to be considered for this program. 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:

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; a new Statement of Support must be completed and signed by the applicant's next appointment to continue eligibility for the SFDP.

To be completed by the applicant:

I, ____, declare that I have no employment and do not have income of any kind.

Number of dependents: _______

Print Full Name: ____ DOB:_________________

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

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: ______________

25 Northridge Lane • Lexington, VA 24450
(540) 464-8700 • www.rockahc.org • *fax*: (540) 464-1323

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 safety net 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 above named 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. 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.

This consent form will be used as needed. You may revoke or change any of the above consents at any time.

When signing the electronic signature pad at RAHC before your first visit, you acknowledge:

1) review of RAHC's General Consent;
2) review of RAHC's Notice of Privacy Policy effective June 2, 2014;
3) review of RAHC's Patient Rights and Responsibilities

PATIENT RIGHTS & 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.

HEALTH INSURANCE ASSISTANCE

Get Healthy! Get Insured! Rockbridge Area Health Center offers FREE in-person assistance to help with options through the Affordable Care Act as well as help with completing Medicaid applications, which are accepted throughout the year. For questions about health insurance enrollment, please call our Outreach and Enrollment team at (540) 464-8700, option 1.

ENABLING SERVICES

At RAHC we want to break down any barriers to receiving healthcare services and having a healthy lifestyle. We are here to help you. Whether your barriers are due to receiving affordable healthcare, transportation problems, lack of good food or shelter, language or reading challenges, or any number of other obstacles, we want to help.

Enabling services include:

- Financial assistance for RAHC services through our Sliding Scale Program for medical, dental, and integrated health services
- Enrollment assistance with private health insurance through the Marketplace and Medicaid
- Medication Assistance Program for eligible patients who have difficulty paying for prescription medications
- Every Woman's Life (EWL) program to help uninsured, low-income women gain access to free breast and cervical cancer screening services.
- Interpretation and translation services
- Transportation assistance – both to the RAHC and to specialists we may refer you to see (within and outside of the Rockbridge area)
- Help finding affordable medical equipment
- Resource information on:
    - Obtaining food for your household
    - Housing, fuel or utility assistance
    - Substance abuse treatment
    - Domestic abuse
    - Health education

Healthcare does not just take place within the walls of the RAHC. It's also about what you are doing and experiencing outside of the Health Center. We want to do everything we can to help you take care of yourself. For all enabling services (except for medication and financial assistance) call the Patient Services Coordinator at (540) 464-8700, ext. 7117.

MEDICATION ASSISTANCE

RAHC offers two medication assistance programs: the **340B Program** and the **Medication Assistance Program (MAP).**

1- The **340B Program** offers reduced cost medications to RAHC patients that are insured and uninsured (excluding Medicaid). RAHC is partnering with Lexington Prescription Center to better serve you. We encourage all of our patients to use Lexington Prescription Center for all your medication needs. The Lexington Prescription Center is a full service pharmacy located at 800 S Main Street, Lexington, offering:

- drive thru pick up
- on line refill request
- home delivery
- representatives available to assist in all insurance billing
- home oxygen and sleep apnea supplies with
- a qualified staff of Respiratory Therapists
- extended hours including weekends

Transferring your prescription is easy, call 540.463.9166 and ask them to contact your pharmacy to move your prescriptions.

2- The Medication Assistance Program (MAP) helps patients by providing access to medications offered by major pharmaceutical companies. To qualify for the Medication Assistance Program:

- You must be a patient of the Rockbridge Area Health Center.
- You must not have prescription insurance coverage.
- You must follow your provider's instructions regarding periodic re-evaluations, lab work, etc.
- You must have a medical appointment with your RAHC Primary Care Provider every three (3) months unless otherwise instructed by your RAHC Primary Care Provider.
- You must meet federal income guidelines.
- You must complete all required paperwork to include completing the annual re-enrollment process.
- You must provide specific documentation of household income when requested.

* Note: a $40 administrative fee is assessed annually to participate in the program.

If you have any questions, please call our Medication Assistance coordinator at 540.464.8700, ext. 7114.