



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				
Last Name	First Name	Middle Name		
Date of Birth	Social Security Number			
Gender <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		
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?		Name of Employer		
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed				
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= \$24,280 2 people= \$32,920 3 people= \$41,560 4 people= \$50,200 5 people= \$58,840 6 people= \$67,480

**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 No If yes, from which practice?

Are you transferring dental care to RAHC? Yes No If yes, from which practice?

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. *For example, we report that we serve 100 veterans.*

Veteran Status: Have you ever been in the Armed Forces of the United States? Yes No

Are you active duty military? Yes No

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 race <input type="checkbox"/> Unreported/refused to report	
Ethnicity: <input type="checkbox"/> Hispanic or Latin American <input type="checkbox"/> Non-Hispanic <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"/> Something else <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



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: _____

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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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: _____