Rockbridge Area
Health Center

Patient Registration Form

Please select your preferred time: ❒ 8:30 am – 10:30 am ❒ 10:30 am – 12:30 pm

Patient's Full Legal Name

Full Name

Date of Birth | Social Security Number

Gender ❒ Male ❒ Female ❒ Unknown | Marital Status ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Mailing Address

City | State | Zip Code | County/City of Residency

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 access your vaccine record from this portal

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

Additional Information

Do you have medical insurance: ❒ Yes ❒ No If yes, Primary Medical Insurance:

Plan ID Number | Plan Group Number

Policy Holder Name | Date of Birth | Social Security Number

Policy Holder Address | Phone Number

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

Race: ❒ Asian ❒ White ❒ Black or African American ❒ Pacific Islander
❒ American Indian or Alaskan Native ❒ Other race ❒ Unreported/refused to report

Name of Emergency Contact | 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. (For minor patients, parent/legal guardian completing this form sign below)

Signature | Print Name

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
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: _____

City: _____ State: _____ Zip Code: _____

I give permission for RAHC to mail my COVID-19 test results to the address listed in registration:

☐ Yes ☐ No

If a copy of results are needed, I will come in at a later time to obtain them:

☐ Yes ☐ No

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

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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 secure 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 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. CONSENT TO COMMUNICATE VIA SMS. I authorize RAHC through its vendors to contact me by SMS text message to serve me better. RAHC may send me text messages to help me or my child stay healthy, including:(Timely reminders about doctor or dental appointment, health maintenance reminders, and information to help manage illnesses)
   - I understand that message/data rates may apply to messages sent through RAHC to my cell phone and that I may receive up to 10 texts per month.
   - I know that I am under no obligation to authorize RAHC to send me text messages as part of this program.
   - I may opt-out of receiving these communications from RAHC at any time by calling RAHC at 540-464-8700

5. 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.
Participation in all of the programs offered at RAHC is voluntary and is not a requirement to receive care.

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

1) review of RAHC's Consent to File Insurance/Correct Information.
2) review of RAHC's Notice of Privacy Policy effective June 2, 2014;
3) review of RAHC's Consent for Treatment
4) review of RAHC's Consent for Text Communication
5) review of RAHC's Consent for Bloodborne Pathogens

_____

Signature of Patient or Patient's Representative Date

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