Rockbridge Area Health Center

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

Patient's Full Legal Name

Full Name

Date of Birth | Social Security Number

What is your sex:
❒ Male ❒ Female ❒ Chose Not to Disclose

Marital Status:
❒ Single ❒ Married ❒ Divorced ❒ 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? ❒ 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 request medication refills, view lab results and more.

For minors:
Is there a custody order on file? ❒ Yes ❒ 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?
❒ Full-time ❒ Part-time ❒ Self-Employed ❒ Retired ❒ Not Employed

Name of Employer

Employer Address | City | State | Zip Code

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

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

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.

Additional Patient Information

We collect information on our patients to help us know more about the community we serve, to improve our services, and to apply for additional funding. We report this information without identifying patients personally.

For example, we report that we serve 100 veterans.

Veteran Status: Have you served in the United States military, armed forces, or uniformed services?

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. ❒ Yes ❒ No

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: _____ ❒ Unreported/refused to report

Preferred Language: _ Do you require assistance with language interpretation? ❒ Yes ❒ No

What is the estimated total annual household income before taxes, including wages and disability? (circle one below)

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

$45,001- $55,000 $55,001- $65,000 $65,001- $75,000 $75,001- $85,000 Over $85,000 Choose not to disclose

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*

Residence: Are you a seasonal resident? ❒ 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

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

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 ❒ Medical ❒ Financial

Home or Cell Phone Number Relationship to Patient

Name of Emergency Contact #2 Permission to discuss ❒ Medical ❒ 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

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: _____

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		Substance Use Disorder
	X-Ray Results		Mental Health Record		HIV/AIDS Info		Other:

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 which shall remain in effect one year from the date of the request unless otherwise stated.

_____

Patient/Legal Guardian Signature

_____ _____

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 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**)

	Dental Records		Imaging

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

	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

25 Northridge Lane • Lexington, VA 24450
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Rockbridge Area Health Center

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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(540) 464-8700 • www.rockahc.org • *fax*: (855) 806-0826

Rockbridge Area Health Center

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.

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Rockbridge Area
Health Center

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: _____

25 Northridge Lane • Lexington, VA 24450
(540) 464-8700 • www.rockahc.org • *fax*: (855) 464-806-0826

Rockbridge Area
Health Center

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 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.