Blue Ridge
MEDICAL CENTER

4038 Thomas Nelson Highway, Arrington, VA 22922, Tel. 434.263.4000, FAX: 434.263.4160

Welcome!

Dear New Patient:

Welcome, and thank you for choosing Blue Ridge Medical Center (BRMC) for your health care needs. Once registered, you are eligible for services at all of our locations, including Blue Ridge Medical Center Amherst, Blue Ridge Medical Center Appomattox, Blue Ridge Medical Center Pharmacy and at the Blue Ridge Dental Center. Please fill out all forms in the enclosed packet and return them to the Medical Center before your appointment. Having the documents in advance will make your check-in process go much faster.

The forms included in this packet are:

Patient Registration	Return to BRMC
Request for Medical Records	Return to BRMC
No Show Policy	Return to BRMC
BRMC Website Access Form	Return to BRMC (if applicable)
Application for Financial Assistance	Return, if applicable
Patient Rights and Responsibilities	For your information
Notice of Privacy Practices	For your information

Forms that are incomplete will be returned.

Please contact us as soon as possible if you have questions about any of the forms. We will be happy to assist you. And again, thank you for choosing Blue Ridge Medical Center

Sincerely,

Blue Ridge Medical Center
434.263.4000

Blue Ridge MEDICAL CENTER

PATIENT REGISTRATION FORM

DATE:_____

Registration is for ☐ Medical (BRMC) ☐ Dental (BRDC) ☐ Both

PATIENT INFORMATION					
Last Name	First Name			Middle Initial	
Mailing Address	City		State	Zip	
Home phone	Cell Phone		Work Phone		
Date of Birth (mm/dd/yyyy) _ _/_ _/ _ _ _ _	Age	Gender at Birth ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other		
	Social Security #		Secondary Phone #		
Employment ☐ Full-Time ☐ Part-time ☐ Retired ☐ Student ☐ Other _____			Working Status ☐ Migrant ☐ Seasonal ☐ Neither		
Employer Name	Employer Address				
	City		State	Zip	

IN CASE OF EMERGENCY			
Emergency contact person's name	Relationship to Patient		
Address	City	State	Zip
Primary Phone	Secondary Phone	Other Phone	

RESPONSIBLE PARTY (GUARANTOR)			
Guarantor's Last Name	First Name		Middle Initial
Mailing Address (If different from patient)	City	State	Zip
Guarantor's Phone Number		Date of Birth (mm/dd/yyyy) __ __/__ __/ __ __ __ __	

INSURANCE INFORMATION		
Name of primary medical insurance	Policy subscriber's name, if not patient	Policy subscriber's Date of Birth
Name of dental insurance	Policy subscriber's name, if not patient	Policy subscriber's Date of Birth
Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify _____		

CONTACTING YOU
Tell us where to call you, leave you messages and appointment reminders: ___Home ___Cell___Work
Can BRMC/BRDC leave messages on the phone numbers you have provided? ☐ Yes ☐ No If yes, may we leave: Brief messages with no clinical information, *OR* ☐ Yes ☐ No Extended messages with some clinical information ☐ Yes ☐ No } *Please choose one*
E-mail address(We will not share this with any other entities)

PRIVILEGE TO DISCUSS: Please list all individuals with whom we may discuss your medical care.

NAME (First and Last)	**Date of Birth (mm/dd/yyyy)**	**Relation to patient**
	_ _/ _ _/ _ _ _ _	
	_ _/ _ _/ _ _ _ _	

Blue Ridge MEDICAL CENTER

PATIENT REGISTRATION FORM

DATE:_____

As a medical center that receives some federal funding, the following information will help us tailor our services to better meet your needs and to obtain grants and other funds to continue improving our practice. *THANK YOU* in advance for your assistance.
RACE (check all that apply): ☐ White ☐ Asian ☐ Black/African American ☐ Native American/Alaskan Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other (specify) _____ ☐ Decline to state ☐ Unknown
ETHNICITY: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown | PRIMARY LANGUAGE SPOKEN: ☐ English ☐ Spanish ☐ Italian ☐ Other
Will you need an interpreter? ☐ Yes ☐ No | HOUSING: ☐ Single Family ☐ Multi-Family ☐ Apartment ☐ Other
LIVING SITUATION: ☐ Homeless Shelter ☐ Street ☐ Doubling Up (sharing space) ☐ Transitional ☐ Other ☐ Unknown | Are you a veteran of the US Armed Forces? ☐ Yes ☐ No
Household size: _____ Annual household income: (please check the appropriate range) ☐ $0 - $50,000 ☐ $50,001 - $100,000 ☐ $100,001 or above ☐ Decline to state
Sexual Orientation: ☐ Lesbian or Gay, ☐ Straight (not lesbian or gay) ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose
Do you identify your gender as: ☐ Male, ☐ Female, ☐ Transgender Male to Female, ☐ Transgender Female to Male, ☐ Other, ☐ Choose not to disclose
Do you have an Advance Directive on file with our office? ☐ Yes ☐ No
Would you like information about Advance Directives? ☐ Yes ☐ No
Pharmacy Selection
☐ Blue Ridge Medical Center Pharmacy ☐ Other

Please read the items below and initial beside each item, then sign and date as noted.	**Initial below**
PRIVACY PRACTICE: I have read and understand the BRMC/BRDC "Notice of Privacy Practices."	
MEDICAL RECORDS: I give permission to BRMC/BRDC to obtain medical records from any provider, practice or pharmacy where I have received services in order to optimize my care.	
NO SHOW: I understand that there is a policy in place for patients who fail to arrive for their appointments. In the event that I do not contact BRMC/BRDC at least 24 hours in advance of my appointment to cancel or reschedule I understand that BRMC/BRDC can take action up to and including dismissing me from the practice	
INSURANCE: I authorize BRMC/BRDC to furnish information to my insurance company regarding my health or healthcare or dental care. I assign BRMC/BRDC to receive payment from insurance claims filed by BRMC/BRDC for medical/dental services. I understand that I am responsible for the payment of all fees and that I am ultimately responsible for making sure my insurance will cover appointments with BRMC/BRDC and with specialists to whom I am referred by BRMC/BRDC.	
PATIENT PAYMENT RESPONSIBILITY: I understand that I am responsible for payment for services received at BRMC/BRDC, whether full fee, nominal fee or sliding scale. Insured patients acknowledge responsibility for co-pays, deductibles and co-insurance payments. *All unpaid balances are subject to collections fees.*	
AUTHORIZATION TO TREAT: I Authorize BRMC/BRDC to treat me for the conditions for which I present to the center.	

Patient/Guardian Signature _____ **Date** _____

Please have your insurance card available at check in.
The Front Desk representative will take your photograph so that we can accurately identify you at each visit.
The photo is for internal use only.

How did you hear about BRMC/BRDC? ☐ Family/friend ☐ Newspaper ☐ Radio/TV/Billboard ☐ Social Media ☐ Internet Search ☐ Other (specify) _____

FOR OFFICE USE ONLY					
Entered ☐ Yes ☐ No	Date:	Initial	**Scanned** ☐ Yes ☐ No	Date:	Initial

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CONSENT TO EXCHANGE MEDICAL, BEHAVIORAL HEALTH AND DENTAL RECORDS

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide and coordinate these services or benefits.

A SEPARATE FORM must be completed for EACH PROVIDER with whom you are requesting records be exchanged!

Patient Name	Date of Birth	Social Security Number
Address		Phone number
Person giving consent	Relationship to patient ☐ Self ☐ Parent ☐ Guardian ☐ Power of Attorney	

I want Blue Ridge Medical Center and the following agency to exchange this information:	
Address	Phone

The items checked below indicate the confidential information about the patient to be exchanged for dates: _____to_____

Medical/Dental:

☐ All Records ☐ Office Notes ☐ Medical diagnoses ☐ Out Patient Records ☐ Admission Reports

☐ Labs ☐ Medical Imaging ☐ Discharge Summary ☐ Pharmacy Records ☐ Emergency Department Report

☐ Immunizations ☐ Physical Therapy ☐ Dental Records & Imaging

Behavioral Health:

☐ Assessments ☐ Psychiatric Records ☐ Mental health diagnoses ☐ Psychological Records ☐ Criminal Justice Records

☐ Substance abuse/HIV or Hepatitis Information

Other:

☐ Educational Records ☐ Social/family history ☐ Billing Records ☐ Other: _____

I want the information exchanged ONLY for the following purpose(s) (Check all that apply):

☐ Assessment and evaluation ☐ Service coordination, referral & treatment ☐ Eligibility determination ☐ Insurance ☐ Attorney

☐ Self/personal copy ☐ Transfer/continuity of Care ☐ Other:_____

I want the following types of information to be shared (Check all that apply):

☐ Written information ☐ Computerized Data ☐ Verbal, Meetings or Phone

This consent is good for one year from the date of signature.

I understand that: I can withdraw this consent at any time by submitting my request to the appropriate agency in writing. This will stop the listed agencies from sharing information after they know my consent has been withdrawn: I have the right to know what information about me (or my child) has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information; I want all agencies to accept a copy of this form as a valid consent to share information. *If I do not sign this form, information will not be shared and I will have to contact each agency to give them information about me (or my child) that they need.*

Signature _____ Date _____

☐ I request that someone explain this form to me.

Person Explaining Form _____ Date_____ Witness (if required) _____ Date _____

Notice: The information approved for disclosure by this authorization may be protected by Federal Regulations (42 CFR Part 2) which prohibits a recipient from making any further disclosure of alcohol or substance treatment information unless expressly permitted by written authorization of the person to whom it pertains or otherwise permitted by 42 CFR Part 3. These Federal Regulations also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. 42 CFR limits those who may act in place of the client who has been adjudicated mentally incompetent to individuals who have been appointed the client's legal guardian. 42 CFR permits limited disclosures about deceased clients when required by federal or state laws for the collection of vital statistics or an investigation into the cause of death. Any other disclosure of information identifying a deceased client as an alcohol or drug abuser is subject to the 42 CFR.

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Thank you for choosing Blue Ridge Medical Center for your health care needs. At our Center you can expect caring professionals to provide you with the highest quality care. Patients at our Center have rights and responsibilities. These lists are part of the registration packet and are posted in various places in the building. A very important patient responsibility is to keep your appointment, and to arrive on time. This helps us to give you good care and keeps access open for others in the community who also need to be seen. Please take some time to read through the following statements and indicate that you understand them. If you have any questions please ask at the front desk. We will be glad to explain further.

Thanks again!

1. I understand that if I no-show or cancel an appointment with a notice of less than one full business day, the appointment can only be rescheduled with provider approval. _____ Initial

2. I understand that if I have three no-show appointments within 12 months I will be notified that I will first be required to meet with a Patient Services Team Leader or other designated staff to discuss my missed appointments before I can schedule again at Blue Ridge Medical Center. Any additional missed appointment after this documented conversation occurs will result in discharge from the practice. _____ Initial

3. If, as a Parent/Guardian I cause a pediatric patient to have 3 missed appointments during the vital periods of infancy and/or pediatric immunizations or if my child/children have diagnosed health conditions that require frequent monitoring, and Blue Ridge Medical Center is unable to contact me, I will be referred to Child Protective Services. _____ Initial

4. I understand that I should arrive for an appointment at least 15 minutes before the scheduled time with my provider; and that if I arrive after my appointment time, the provider will decide whether I will need to reschedule. _____ Initial

_____ _____
Signature Date

_____ _____
Print Name Date of Birth

For office use only

Date Received: _____

Returned by: _____

BRMC Staff: _____

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4038 Thomas Nelson Highway, Arrington, VA 22922
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APPLICATION FOR FINANCIAL ASSISTANCE - SLIDING SCALE PROGRAM

APPLICATIONS WILL NOT BE PROCESSED ON THE DAY OF SERVICE!
Applications without proof of all Income or Support will NOT BE PROCESSED!
(See back for instructions.)

Name: _____ SSN: _____ Birth Date: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Telephone #: Home: _____ Cell: _____ Work: _____

"*Family/Household*" includes the Applicant and dependents** (as defined by IRS), *AND* any SPOUSE / PARTNER / FIANCE in the home.

** If someone claims you as a dependent, then list all other family members.

Family/Household members: *If more space is needed, attach a separate sheet.*	Date Of Birth	Relationship To Applicant	Monthly Gross Income: *PROOF is required (See Back)*	Employer Name (if employed) or Source of Income	Full Time Student? Yes/No	Race (ie: White, Asian, African American, Native American, etc.)
		Self				

How many are in your family/household? _____ If Unemployed, date employment ended: _____

Applicant: How often are you paid? _____ Date Employment Began: _____ Employer Phone No.: _____

Other: How often are you paid? _____ Date Employment Began: _____ Employer Phone No.: _____

If you have NO, or VERY LOW, income *PROVIDE PROOF* of how you are supported? _____

PROVIDE *PROOF* / DOCUMENTATION of any of the following as well:

Food Stamps: Yes / No Amount: $	Unemployment wages: Yes / No Amount: $
Child Support: Yes / No Amount: $	Disability: Approved or pending Yes / No Amount: $
Spousal Support: Yes / No Amount: $	Do you *Receive* rental income? Yes / No Amount: $

Do you or others in the household have health insurance? Yes / No Name(s): _____ Insurance? _____
(including Medicare or Medicaid) Name(s): _____ Insurance? _____

DECLARATION: The information provided above is, to the best of my knowledge and belief, complete, accurate and true. I understand that if I give false information, withhold information, or fail to report changes in my income, I will be disqualified from this program; and could be prosecuted for perjury, larceny, and/or fraud. I authorize the release of all information which Blue Ridge Medical Center may need to determine whether I qualify for financial assistance through the Sliding Scale Program.

Applicant Signature:	Date:
Other adult and/or Partner Signature: (see # 3 on Reverse)	Date:

Office Use Only (below this line)

BRMC: Income: _____ S.S. Status: _____ Eff. Dates: _____ Migrant? _____ Date/Init.: _____

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Applications without proof of ALL Income or Support WILL NOT BE PROCESSED!

Blue Ridge Medical Center Pharmacy charges and charges for some Dental procedures and services are exempt from the Sliding Scale. However, some discounts may apply for eligible patients. Eligibility will be based on information supplied in this application.

1. **Fill in every blank field and *ATTACH PROOF OF ALL INCOMES***.
   If no income, see "UNEMPLOYED - NO INCOME", below. Incomplete applications & applications missing income documentation/support ***will*** be returned and significantly delay processing. **You will be expected to pay full fee for charges until your application is complete.**

2. **Other Adults in home**: If you are a spouse/partner/boyfriend/girlfriend/partner/fiancé, or otherwise "significant other", in the home, ***proof*** of your income is REQUIRED. If you are an adult "**dependent**" – see #3.

3. **"Other Adult and/or Partner" -** Please sign this application if you live in the home and wish to be considered for this program **AND** you are either:
   - An adult child of the applicant. (**Dependent adult children must provide PROOF of dependence – IRS 1040**); OR
   - An unmarried partner (fiancé, girlfriend, boyfriend) of the applicant.

The following types of documentation are required, as applicable, to document your income:

- **EMPLOYED**:
  - If employed during total of previous tax year, then the prior year's IRS 1040 Income Tax Return, or
  - 1 month's worth of **CURRENT** pay stubs showing gross income, or
  - A letter from your employer stating 1 current month's gross salary

- **SELF EMPLOYED**: Prior year's Federal Income Tax return (IRS 1040), along with Schedule C

- **UNEMPLOYED – LOW/NO INCOME:** Written statement from family or friend verifying financial support and lack of income &/or employment.

- **UNEMPLOYMENT/WORKER'S COMPENSATION:** Documentation verifying weekly benefit amount, or Denial

- **GOVERNMENT BENEFITS**: Social Security, SSI, VA, Disability, or other government benefits
  - Social Security Letter confirming or denying, and listing monthly gross amount (Bank statement can **NOT** be used)
  - IRS 1099 showing yearly amount (if received for total year)

- **SOCIAL SERVICES:**
  - SNAP "Notice of Action" for Food Stamps, Aid to Dependent Children, TANF, Housing, etc.

- **OTHER RESOURCES**: Provide legal proof, or official award letter
  - Retirement benefits
  - Trust fund allotments
  - Child Support and/or Alimony – received only

- **HOMELESS:** Letter from shelter, if client is homeless

- **LIQUID ASSETS**: Provide statement(s) from Bank or Credit Union
  - Investments, CD'S, Interest, Dividends

- **OTHER:** As appropriate - Copy of custody papers for dependents listed, if income is too low to file taxes.

Comments: ***You may use this area to explain any unusual circumstances which you feel may be helpful.***

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PATIENT RIGHTS

As a patient of the Blue Ridge Medical Center you have the right to:

1. You have the right to know about your illness, treatment, and what might happen later. This information will be given to you by providers and other medical staff in language you can understand.
2. You have the right to make decisions about your treatment. You have the right to know why you need care or treatment and who will perform that care or treatment.
3. You have the right to refuse care or treatment and to know what may happen if you do not have this treatment.
4. You have the right to know the name of the provider who is in charge of your care. You also have the right to know the names of all other medical center staff taking care of you.
5. You have the right to have all information about your illness and care treated as confidential.
6. You have the right to review your bill and ask questions you may have about it.
7. You have the right to access your medical and billing records.
8. You have the right to agree or refuse to take part in any study or experiment related to your care or treatment.
9. Health care is best when there is an open, trusting, and helpful relationship between you and the people taking care of you. We will make every effort to see that you receive the best care we can give.
10. We would like to know if you have any concerns about your treatment, care or safety. Please discuss them with your medical care provider, nurse, or the Chief Executive Officer.

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PATIENT RESPONSIBILITIES

As a patient of the Blue Ridge Medical Center (BRMC) we respectfully request that you:

1. Arrive on time for your appointments
2. Cancel appointments that you cannot keep.
3. Provide all information necessary for billing and insurance processing.
4. Be respectful of the property of other persons and of BRMC.
5. Be considerate of other patients and BRMC personnel.
6. Adhere to the BRMC “no weapons” on the property policy.
7. Control noise and language
8. Extinguish any smoking materials. (BRMC is a smoke-free facility. This includes the entire property.)
9. Bring your medications with you to each visit.
10. Communicate your care needs and concerns to your medical care provider.
11. Be an active participant in determining your plan of care with your healthcare provider.
12. Follow your plan of care and take responsibility for your actions if you refuse to follow the treatment plan.
13. Understand and meet your financial obligations to Blue Ridge medical Center.
14. Let the Chief Executive Officer know or fill out a patient suggestion form if you would like to share thoughts, feelings or concerns about your care or our service.

BRMC Website Access Form

If you would like to view your Personal Health Information online, please complete this form and hand it to the Front Office Staff. We will send you a computer-generated e-mail with your personal username and password.

Name: _____ Date of Birth: _____

Yes, I would like to be added as a user of the Patient Health Website.

Please use this e-mail address* _____ to send me my user name and password for the BRMC Personal Health Information Website.

Signature: _____ Today's date: _____

Please complete the information below to link information for your minor children (add the names and dates of birth for your minor children to enable access to the children's accounts). If your spouse or significant other would also like access, please have him/her complete the additional form on the back of this page. (*Note: When your child turns 18 only he/she will have access to their personal health information.)*

Child 1 _____ Date of birth _____

Child 2 _____ Date of birth _____

Child 3 _____ Date of birth _____

Child 4 _____ Date of birth _____

Child 5 _____ Date of birth _____

*e-mail is required for online interaction.

Advanced Medical Directives
Your Right to Decide and
Communicating Your Health Care Choices

Blue Ridge Medical Center supports your right to make decisions about your own medical care now and in the future. It is important that you clearly communicate your wishes regarding your care to your medical care provider so they can be considered for all aspects of your care at Blue Ridge Medical Center.

In 1990, Congress passed the **Patient Self-Determination Act** that requires health care facilities to tell patients and the community about their right to make decisions about their medical care. These rights include the right to accept or refuse care and the right to create Advance Medical Directives.

We never know when a serious illness will leave us incapable of making our own health care decisions. For peace of mind, it is important to think about and talk about your values and wishes for medical care with your loved ones and to put these wishes in writing.

An **Advance Medical Directive** is a written plan that expresses your decisions about your health care if you become unable to make your own health care decisions.

Concerning the ***Life Prolonging Treatment*** portion of your Advance Medical Directive, Blue Ridge Medical Center will stabilize you/the patient and transfer care to a hospital. A copy of your/the patient's Advance Medical Directive will accompany you/the patient.

Ask your medical provider for more information if you do not have an Advance Medical Directive on file with Blue Ridge Medical Center. Your provider or nurse can give you more information and help you complete the necessary documents.