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 also eligible for services at 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
Pharmacy Patient Profile	Return to BRMC
BRMC Website Access Form	Return to BRMC
Application for Financial Assistance	Return, if applicable
Patient Rights and Responsibilities	For your information
Notice of Privacy Practices	For your information

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,

Audrey Camden

Audrey Camden
Patient Services Coordinator
(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	
Tell us where to call you, leave you messages and appointment reminders: ___Home ___Cell___Work			
Can BRMC/BRMD 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)	Social Security Number		
Date of Birth (mm/dd/yyyy) _ _/_ _/ _ _ _ _	Age	Sex	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
Employer Name	Employer Address City	State	Zip
Employment ☐ Full-Time ☐ Part-time ☐ Retired ☐ Student ☐ Other _____	Working Status ☐ Migrant ☐ Seasonal ☐ Neither		

IN CASE OF EMERGENCY			
Emergency contact person's name	Relationship to Patient	Date of Birth (mm/dd/yyyy) __ __/ __ __/ __ __ __ __	
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	Secondary 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 _____		

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: _____ Decline to state ☐	

Do you have an Advance Directive on file with our office?	☐ Yes ☐ No
Would you like information about Advance Directives?	☐ Yes ☐ No

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 providers.	
UNINSURED 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.	
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 ☐ Other (specify) _____

FOR OFFICE USE ONLY

Entered ☐ Yes ☐ No	Date:	Initial	**Scanned** ☐ Yes ☐ No	Date:	Initial

Blue Ridge MEDICAL CENTER

Pharmacy's Patient Profile

The pharmacy would like to update your records. Would you compare the information on your prescription bag receipt and note any changes on this form. (Don't forget to add your name and birth date please.) If you would like to mail this back to us please ask for a stamped, addressed envelope. Please list any new medication allergies or medical conditions, including a pregnancy due date that we may not know about. This information will be kept confidential and is requested by the Blue ridge Medical Center Pharmacy, as required by state regulation, so that we can provide appropriate pharmacy services to you. Thank you for your assistance.

Patient's Last Name _____

Patient's First Name _____

Street Address _____

_____

City_____

State _____ Zip _____

Phone Number (____) _____-_____

Alternate Number (____) _____ -_____

(For example, cell phone or number of close relative)

Work phone (____) _____- _____

E-mail (optional) _____

Date of Birth _____/_____/_____

Pregnancy due date _____/_____/_____

Social Security Number _____-_____-_____

Sex (check one) ☐ Male ☐ Female

Race: ☐ Asian ☐ Black ☐ Hispanic

☐ Native American ☐ White ☐ Other

Please check and continue on back/below

Language Preferred: ☐ English ☐ Spanish

Please present Insurance Card

Cardholder: _____

Relationship to Cardholder: Spouse, Child, Student

Would you like us to use generic medications when possible? (BRMC policy is to use generics whenever they are available. We are required to use them for most insurance cards and BRMC prescription assistance plans.)

☐ Yes (will be considered "yes" if no box is marked) ☐ No

If you have children in your household, to prevent accidental drug poisoning, please specify child resistant packaging: Would you like us to dispense your medications in child resistant packaging? ☐ Yes ☐ No

Please List Medical Conditions in the Following Boxes:

1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.

Blue Ridge Medical Center
4038 Thomas Nelson Highway
Arrington, VA 22922

Phone (434) 263-4810
Fax: (434) 263-6360

(Form 1002G rev 11/2011 dw/nfr)

Blue Ridge MEDICAL CENTER

Pharmacy's Patient Profile

	Current Medications: Prescription/OTCs/Herbals			Allergies: Food and Medications
1			1	
2			2	
3			3	
4			4	
5			5	
6			6	
7			7	
8			8	
9			9	
10			10	
11			11	
12			12	
13			13	
14			14	
15			15	

Signature _____ Date ____/____/_____ Relationship to Patient _____

I do not wish to provide this information:

Signature _____ Date ____/ ____/ _____ Relationship to Patient _____

(A minimum of name, street address, and date of birth are required to fill your prescription(s). Thank you – BRMC Pharmacy)

Blue Ridge Medical Center
4038 Thomas Nelson Highway
Arrington, VA 22922

Phone (434) 263-4810
Fax: (434) 263-6360

(Form 1002G rev 11/2011 dw/nfr)

Blue Ridge
MEDICAL CENTER

4038 THOMAS NELSON HWY PH: 434-263-4000
ARRINGTON, VIRGINIA 22922 F: 434-263-4160

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 Blue Ridge Medical Center to use and disclose To ☐ Or Obtain from ☐

_____ _____
Name of Facility or Person Phone Number/Fax Number

_____
Street Address City State Zip Code

I am requesting the following documentation to be released: (check all that apply)

Dates ranging from_____to_____

	All Records		Physical Therapy Notes
	Lab Results		Immunization Record
	X-Ray Results		Mental Health Record
	HIV/AIDS Information		Dental Records & Imaging
	Pharmacy Records		EKG Reports
	Physician Office Notes		
	Other :		

The purpose for the release of information at the request of the individual is :

	Attorney		Disability
	Insurance		Workman's Comp
	Self/Personal Copy		Other :
	Transfer or Continuity of Care		

I understand that I have the right to revoke this authorization by submitting my request in writing. I further understand that Blue Ridge Medical 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 Date

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

BLUE RIDGE MEDICAL CENTER 2016

4038 Thomas Nelson Highway, Arrington, VA 22922
Phone: 434-263-4000 Fax: 434-263-4160 Email: slide@brmedical.com

APPLICATION FOR FINANCIAL ASSISTANCE - SLIDING SCALE PROGRAM

Applications without proof of all Income(s) or Support will NOT BE PROCESSED (See Back for help)*

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.**

List of Family/Household members: *If more space is needed, attach a separate sheet.*	Date Of Birth	Relation To Applicant	Monthly Gross Income: ***PROOF IS REQUIRED (See Back for Help)***	Employer Name (if employed); Or Source of Income	Full Time Student?	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.: _____

APPLICATIONS WITHOUT PROOF OF ALL INCOME(S) OR SUPPORT WILL NOT BE PROCESSED

SEE BACK

BLUE RIDGE MEDICAL CENTER 2016

4038 Thomas Nelson Highway, Arrington, VA 22922
Phone: 434-263-4000 Fax: 434-263-4160 Email: slide@brmedical.com

Applications without proof of ALL Income(s) or Support WILL NOT BE PROCESSED*

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.***

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.

Blue Ridge MEDICAL CENTER

4038 Thomas Nelson Highway I Arrington Virginia 22922 I Ph: 434-263-4000 I F: 434-263-4160

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 have all information about your illness and care treated as confidential.
5. 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.
6. You have the right to agree or refuse to take part in any study or experiment related to your care or treatment.
7. You have the right to review your bill and ask questions you may have about it.
8. 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.
9. 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 Executive Director.
10. If concerns are not resolved by contacting the Executive Director you are encouraged to contact the Joint Commission at: Division of Accreditation Operations Office of Quality Monitoring:

The Joint Commission

Division of Accreditation Operations Office of Quality
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Ph: 630-792-5636
E-mail: complaint@jcaho.org

Blue Ridge
MEDICAL CENTER

4038 Thomas Nelson Highway I Arrington Virginia 22922 I Ph: 434-263-4000 I F: 434-263-4160

PATIENT RESPONSIBILITIES

As a patient of the Blue Ridge Medical Center 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 Executive Director know or fill out a patient suggestion form if you would like to share thoughts, feelings or concerns about your care or our service.

Blue Ridge
MEDICAL CENTER

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

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.

Blue Ridge
MEDICAL CENTER

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: _____