

REGISTRATION CHECKLIST

- COMPLETED REGISTRATION FORM (ALL FIELDS MUST BE COMPLETED)
- PHOTO ID
- MANDATORY CRITERIA
 - MY INCOME IS LESS THAN 300%FPL (SEE BACKPAGE)
 - I DO NOT HAVE HEALTH INSURANCE
- PROOF OF INCOME DOCUMENT (PROVIDE ONE)
 - CURRENT TAX RETURN
 - CURRENT W2
 - ONE MONTH PAYSTUBS/PAYCHECK
 - SNAP LETTER / UNEMPLOYMENT BENEFIT LETTER / SOCIAL SECURITY BENEFIT LETTER
 - EMPLOYMENT TERMINATION LETTER / VA TANF / SECTION 8 HOUSING / PENSION
 - ASYLUM REFUGEE STATUS / STUDENT VISA + UNIVERSITY ENROLLMENT LETTER
 - LETTER FROM ANOTHER NONPROFIT INDICATING BENEFITS
- COMPLETED RECORDS RELEASE DOCUMENT
- COMPLETED NOVA SCRIPTSCENTRAL FORM

DATE SUBMITTED: _____

PATIENT SIGNATURE: _____

PLEASE DROP OFF THE COMPLETED APPLICATION PACKET IN THE BOX. YOU WILL BE CALLED ON THE NUMBER PROVIDED ONCE YOUR APPLICATION HAS BEEN REVIEWED.



REGISTRATION FORM

4431 Brookfield Corporate Drive, Unit F
Chantilly, VA 20151
(703) 542-3366 – Office
(888) 965-5824 – Fax
www.achnhealth.org

ALL FIELDS MUST BE FILLED OUT. INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED

PATIENT INFORMATION

Patient's Last Name:		First Name:	Middle Initial	Social Security no.:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date: (mm/dd/yyyy)
Marital status (check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Are you a refugee? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Race <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Middle Eastern <input type="checkbox"/> White <input type="checkbox"/> Other:			Religion <input type="checkbox"/> Christianity <input type="checkbox"/> Hinduism <input type="checkbox"/> Islam <input type="checkbox"/> Judaism <input type="checkbox"/> Other:			
Street address:				City:	State	Zip Code:
Cell Phone:	Home Phone:	Country of Origin:	Email Address: <i>(please use BLOCK letters)</i>			
Chose clinic because/Referred to clinic by (please check one box):						
<input type="checkbox"/> Family		<input type="checkbox"/> Flyer		<input type="checkbox"/> Mosque Announcement		
<input type="checkbox"/> Online		<input type="checkbox"/> Dr. _____		<input type="checkbox"/> Hospital <input type="checkbox"/> Friend		
<input type="checkbox"/> Other (specify): _____						

HOUSEHOLD INFORMATION

Household Size: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Other: _____	Annual/Monthly Income	Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is anyone in the household unemployed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you receive any state benefits? (SNAP, SSI, Disability, TANF, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify: _____	Who is the head of household? <input type="checkbox"/> Male <input type="checkbox"/> Female		Is there anyone over age 55 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any children under age 18 years? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you or anyone in the household have a physical or mental disability/impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No		

PROTECTED HEALTH INFORMATION DESIGNEES

If you are not available at the time that we call, please list below those individuals (designees) with whom we can leave a message or briefly discuss your medical information (e.g. lab or test results, prescription information). This person (designee) will also be able to call the office on your behalf.
Please print the name and relationship to you of each designee below:

Designee Name:	Relationship to Patient:	Phone Number:
Designee Name:	Relationship to Patient:	Phone Number:
Designee Name:	Relationship to Patient:	Phone Number:

ACHN OVERVIEW

I understand that:

- ACHN patient visits are **BY APPOINTMENT ONLY**.
- ACHN does not accept same day appointments or walk-ins.
- Any labs ordered by ACHN are done at discounted rates. Lab charges are collected at ACHN. ACHN will not be responsible if labs are done at a facility other than an ACHN approved facility.

I affirm that I have received the ACHN Office Policy for review. I have read the ACHN Office Policy and agree to comply and cooperative with its implementation. I understand ACHN reserves the right to refuse services to any person that does not abide by or violates said policy.

Patient/Guardian Initial: _____



CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

I hereby give my consent for ACHN Clinic to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I have received the ACHN Clinic Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have reviewed such Notice of Privacy Practices prior to signing this consent and acknowledge that I have studied the Privacy Practices prior to signing this consent. I understand that ACHN Clinic has the right to revise its Notice of Privacy Practices from time to time, and that I may contact this organization in writing at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

With this consent, ACHN Clinic may call or mail my home or other alternative location in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, and any calls or mails pertaining to my clinical care, including laboratory test results, as long as they are marked "Personal and Confidential."

I understand that I may request in writing that ACHN Clinic restrict how it uses or discloses my PHI to carry out TPO. I also understand the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to allow ACHN Clinic to use and disclose my PHI to carry out TPO.

I understand I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, or later revoke it, ACHN Clinic may decline to provide treatment to me.**

Patient/Guardian Initial: _____

I hereby also consent to participate in telehealth visits under the terms described herein, if recommended by my healthcare provider.

I understand that I will be provided information on how the video conferencing technology (telehealth) will be used to in lieu of an office visit before a telehealth visit is scheduled. I understand that this consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. Some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

I understand that my health care provider(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.

Others may also be present during the consultation other than the health care providers in order to operate the equipment. The above-mentioned people will maintain confidentiality of the information obtained. I also understand that I will be informed of their presence during the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.

In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection

I hereby certify that the above information is true to the best of my knowledge. I understand that ACHN Clinic will require proof of income, and I authorize ACHN Clinic to verify my income by any means necessary to complete the application process. I understand that I am financially responsible for any balance/charges. I understand that if any information I have given proves to be false or misleading, my eligibility may be declined and ACHN Clinic may take whatever action becomes appropriate.

_____ <i>Patient/Guardian Signature</i>	_____ <i>Date (mm/dd/yyyy)</i>
Guardian's Full Name:	Relationship with patient:

IN CASE OF EMERGENCY

Name of contact:	Relationship to patient:	Phone Number (cannot be same as page 1):
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OFFICE POLICY

ELIGIBILITY

ACHN eligibility expires 12 months after registration or when household income changes, whichever comes first. It will be your responsibility to inform ACHN if your address, phone number, income or household size changes.

APPOINTMENTS

It is your responsibility to remember when your next appointment is. Reminder calls/texts/emails are a *courtesy only*.

MEDICATION & RECORDS

You must bring all your medications, blood sugar logs, blood pressure logs, and all relevant medical records to each appointment.

LATE SHOWS

If you are more than 15 minutes late to your appointment, you will not be seen and must reschedule. You will also be charged a **\$10 penalty**.

CANCELLATIONS

You must cancel your appointment at least 48 hours in advance. Any cancellation within 48 hours will result in a **\$10 penalty** at the next office visit.

NO SHOWS

If you do not show up to your appointment, you will be charged a **\$10 penalty** at your next office visit. After 2 consecutive no shows, you will lose your eligibility.

MEDICATION REFILLS

You must request medication refills 2 weeks in advance. ACHN **will not expedite any request**.

BLOOD TESTS (LAB) LOCATION

Any blood tests that are paid for at ACHN must be performed at **Sunrise Medical laboratories only**. If you pay at ACHN and go to another lab, ACHN will not be responsible and will not serve as a mediator.

PATIENT PORTAL

All registered patients have access to the patient portal. You may access this patient portal by going to achnhealth.org. All requests for appointments, prescriptions, tests, etc. must be submitted through the patient portal.

EMERGENCY ROOM & HOSPITAL

ACHN **does not** pay for hospital and emergency medical care. ACHN is **not an insurance company**.

CHILDREN

We ask you to not bring your children to your appointment. If you must, they must stay with you at all times. **You will be asked to leave if your children become disruptive**.

GENERAL RULES

Treat staff, volunteers and other patients politely. Wait times can vary, so your patience is appreciated. Please use good cell phone etiquette – your cell phone use should not be disruptive to others.

INAPPROPRIATE BEHAVIOR

ACHN **will refuse services to any person that behaves inappropriately** towards staff, volunteers and/or other patients.

I affirm that I have read and understand the ACHN policy (outlined above) and agree to comply and cooperate with its implementation.

Signature _____

Printed Name _____

Date _____



AUTHORIZATION TO RECEIVE MEDICAL RECORDS/INFORMATION

I authorize the release of my medical records by the organization or physician listed below:

Provider's Name: _____

Provider's Address: _____

Provider's Phone #: _____ Fax # of Provider: _____

Reason for Records Release: _____

These records are to be sent to ADAMS Compassionate Healthcare Network at the ACHN Clinic address listed above.

Patient's Name: _____ Date Of Birth: _____

Address: _____ State: _____ Zip Code: _____

Social Security #: _____ Phone#: _____

The type and amount of information to be disclosed is initialed as follows: (specify dates where appropriate)

____ X-Ray films (Specify type/date)

____ Immunizations

____ Most recent 3 years of Records

____ Entire Medical Record

____ Substance and Drug Abuse, if any

____ AIDS/HIV, if any

____ Genetic testing, from date

____ Psychological or psychiatric conditions,
if any

Other: _____

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I accept full financial responsibility for any copying or shipping fees and any applicable sales tax that may be charged.

Patients Signature

Today's Date

Patient's Representative Signature

Relationship to Patient

**NOVA ScriptsCentral (NSC) Form
for Medication and the Patient Assistance Program (PAP)**



Patient Name _____	Patient DOB _____
Patient Address _____	
Preferred language _____	Allergies _____
Medicaid status: (circle one): Approved Pending Denied Not Applicable	

With this form signed, I give permission until it is revoked by me to share my information in order to obtain medications from NSC. I also give permission for my clinic and NSC to use or share my medical information, and to make my financial information available for review by medication donation partners or its designees for audit purposes.

I understand that my information will not be sold, and I can ask at any time how my information is used and shared and that I can request to see or have a copy of my information. I understand that I can still get medical care from the clinic but not medications from NSC if I do not want my information shared.

I attest that the information given in my application to ADAMS Compassionate Healthcare Network (Clinic name) is true to the best of my knowledge. This includes household income or support, proof of residence, and proof of identity.

I further certify that all personal and financial information given to the clinic is correct. I certify that I will contact NOVA ScriptsCentral and my healthcare provider with any changes in income, insurance or family composition status.

PAP Program

I give permission to the NSC PAP Coordinator to complete all of the necessary documents needed and sign on my behalf for obtaining medication through the Pharmaceutical company programs. I understand that neither NSC PAP Coordinator nor any other party is obligated to complete any particular application or to pursue participation in any program. This signature authorization is valid as long as NSC is assisting me or until I revoke this permission with a writtens statement.

I give informed consent to participate in **NOVA ScriptsCentral** Medication Program & Patient Assistance Program (PAP).

Signature of patient (if under 18, legal guardian) _____

Printed Name of Patient _____ **Date** _____

For Clinic Use:

NOVA ScriptsCentral is accepting the following documents provided by ADAMS Compassionate Healthcare Network (clinic name)

I confirm that the following information is included in the application;

- Proof of Identity (Picture ID)**
- Proof of Income or support (tax return/ W2/ zero income statement/letter of support)**
- Proof of Residence (rental lease agreement, utility bill, medical bill)**

Signature of the Clinic screener: _____ **Phone #** (703) 542-3366

Printed name of Screener: _____ **Date** _____

NEW PATIENT HISTORY FORM



NAME _____

DATE OF BIRTH _____

Preferred Language _____

Reason for Visit

Current Medications

Please list ALL medications you are currently taking, including non-prescription drugs or supplements.

Medication/Product Name

Strength and Frequency

PREFERRED PHARMACY *(Please list your preferred pharmacies for prescriptions.)*

Pharmacy Name

Pharmacy Address

	Pharmacy Name	Pharmacy Address
First Choice		
Second Choice		
Third Choice		

Past Medical History

(Do you have any of the following (Please check all that apply))

- Diabetes
- High blood pressure
- High cholesterol
- Thyroid Disease _____
- Liver Disease _____
- Cancer (type) _____
- Eye Disease _____
- Heart problems
- Angina
- Anemia
- Asthma
- Stroke
- Tuberculosis
- HIV/AIDS
- Stomach or peptic ulcer
- Kidney disease
- Tuberculosis
- Epilepsy (seizures)

Other medical conditions or any surgeries (operations) (please list):

Social History

(Please answer all questions. Put N/A if necessary)

- What is the highest level of education you have completed? (Check one)
Grades: 1 2 3 4 5 6 7 8 9 10 11 12 Associates Bachelor's Masters Doctorate Technical School
- How many people live with the patient? 1 2 3 4 5 6 7 Other _____
- Marital Status: Single Married Divorced Separated Widowed
- Have you ever used any illicit or recreational drugs? Yes No. If yes, please specify? _____
- How often do you drink alcohol?
 Once/twice a year Once a month Once a week Several times a week Daily Never
- Have you ever been involved in an alcohol or drug treatment program? Yes No
- Did your parents or any family member have a problem with alcohol when you were a child? Yes No
- Do you smoke cigarettes? Yes No. If yes, how many? _____
- Have you ever smoked cigarettes in the past? Yes No. When did you quit? _____
- In the past year have you been hit, kicked, or physically hurt by another person? Yes No
- Are you in a relationship with someone who threatens or physically harms you? Yes No
- Have you ever been abused? Yes No
- Do you eat a balanced diet? Yes No
- Do you exercise regularly? Yes No

Family History*(Please describe all family health problems (condition, age of onset, reason for death).)*

Mother

Father

Sibling(s)

Other

AllergiesAllergenSeverity (Mild, Moderate or Severe)What was the reaction**General Review of Symptoms** (Check ALL that apply)**General**

- Recent weight gain
- Recent weight loss
- Decreased exercise tolerance
- Fatigue
- Loss of appetite
- Weakness

Eyes

- Blurry vision or vision loss
- Eye pain
- Redness or dryness

Ear, nose, throat

- Hearing loss
- Difficulty swallowing
- Ear pain
- Ear discharge

Skin

- Hair loss
- Rash

Heart and Lungs

- Cough
- Wheezing
- Shortness of breath
- Chest pain or tightness
- Palpitations
- Swollen legs or feet
- Difficulty lying flat
- Sleep apnea

Psychiatric

- Anxiety
- Stress
- Depression

 Memory loss Restlessness**Muscle/Joints**

- Joint pain or swelling
- Muscle pain
- Stiffness
- Back pain
- Redness of joints

Gastrointestinal

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Heartburn/indigestion
- Change in bowel habits
- Blood in stools

Neurologic

- Confusion
- Headaches
- Dizziness
- Numbness or tingling
- Tremors

Endocrine

- Heat intolerance
- Cold intolerance
- Excessive Sweating
- Frequent urination
- Excessive thirst
- Incontinence

Hematologic

- Easy Bleeding
- Easy Bruising

Patient Health Questionnaire - 9

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Please circle your answer)*

	<u>Not at All</u>	<u>Several Days</u>	<u>More than half the days</u>	<u>Nearly every day</u>
1. Little interest or pleasure in doing things	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Feeling down, depressed or hopeless	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. Feeling tired or having little energy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. Poor appetite or overeating	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7. Trouble concentrating on things such as reading the newspaper, or watching television	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
9. Thoughts that you would be better off dead or of hurting yourself in some way	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

Total Score

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult