REGISTRATION CHECKLIST

- [ ] PROOF OF RESIDENCY
- [ ] 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
  - [ ] LETTERS OF SUPPORT
  - [ ] ONE MONTH PAYSTUBS/PAYCHECK
  - [ ] SNAP LETTER / UNEMPLOYMENT BENEFIT LETTER / SOCIAL SECURITY BENEFIT LETTER
  - [ ] EMPLOYOMENT TERMINATION LETTER / VA TANF / SECTION 8 HOUSING / PENSION
  - [ ] ASYLUM REFUGEE STATUS / STUDENT VISA + UNIVERSITY ENROLLMENT LETTTER
  - [ ] 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.

Adams Compassionate Healthcare Network

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

REGISTRATION FORM

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: ❑ M ❑ F	Birth Date: (mm/dd/yyyy)

Marital status (check one)	Are you a refugee?	Are you Hispanic or Latino?	Preferred Language:
❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	❑ Yes ❑ No	❑ Yes ❑ No	

Race	Religion
❑ Asian ❑ Black ❑ Middle Eastern ❑ White ❑ Other:	❑ Christianity ❑ Hinduism ❑ Islam ❑ Judaism ❑ Other:

Street address:	City:	State	Zip Code:

Cell Phone:	Home Phone:	Country of Origin:	Email Address: *(please use BLOCK letters)*

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Hospital ❑ Friend

❑ Family ❑ Flyer ❑ Mosque Announcement ❑ Online ❑ Other (specify): _____

HOUSEHOLD INFORMATION

Household Size: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ Other: _____	Annual/Monthly Income	Do you have health insurance? ❑ Yes ❑ No	Is anyone in the household unemployed? ❑ Yes ❑ No

Do you receive any state benefits? (SNAP, SSI, Disability, TANF, etc.) ❑ Yes ❑ No If yes, please specify:	Who is the head of household? ❑ Male ❑ Female	Is there anyone over age 55 years? ❑ Yes ❑ No

Are there any children under age 18 years? ❑ Yes ❑ No	Do you or anyone in the household have a physical or mental disability/impairment? ❑ Yes ❑ 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**:* _____

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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.

_____ *Patient/Guardian Signature*	_____ *Date (mm/dd/yyyy)*
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_____

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Adams Compassionate Healthcare Network

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'sAddress:_____

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** _____

NovaScripts Central - 6400 Arlington Blvd #120 Falls Church, VA 22042 Phone number: (703) 532-0269Fax: (703) 532-0372
Email: info@novascriptscentral.org

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
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

Allergies

Allergen	Severity *(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)*	Not at All	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0☐	1☐	2☐	3☐
2. Feeling down, depressed or hopeless	0☐	1☐	2☐	3☐
3. Trouble falling or staying asleep, or sleeping too much	0☐	1☐	2☐	3☐
4. Feeling tired or having little energy	0☐	1☐	2☐	3☐
5. Poor appetite or overeating	0☐	1☐	2☐	3☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0☐	1☐	2☐	3☐
7. Trouble concentrating on things such as reading the newspaper, or watching television	0☐	1☐	2☐	3☐
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☐	1☐	2☐	3☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	0☐	1☐	2☐	3☐
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 ☐

To whom it may concern:

I am writing to inform that I, _____, am currently unemployed and have no source of income. I receive food, shelter and financial assistance in the amount of _____every _____. I have no other forms of income and am unemployed. I live with my _____at _____. If you have any more questions, please reach out to my _____at _____.

Sincerely,

_____

Full Name:

Address:

Notary:

To whom it may concern,

I am writing to inform you that I,_____, provide food, shelter and financial assistance in the amount of _____every _____ for _____. _____ has no other forms of income and is unemployed. If you have any further questions, please contact me at _____.

Sincerely,

_____

Full Name

Address

Notary: