



# REGISTRATION CHECKLIST

## MANDATORY CRITERIA

Do not have health insurance

Income is less than 300% Federal Poverty Guideline 2025 (see below)

Household size	Monthly income at 300% FPL	Annual income at 300% FPL
1	\$3,912.50	\$46,950.00
2	\$5,287.50	\$63,450.00
3	\$6,662.50	\$79,950.00
4	\$8,037.50	\$96,450.00
5	\$9,412.50	\$112,950.00
6	\$10,787.50	\$129,450.00
7	\$12,162.50	\$145,950.00

## COMPLETED REGISTRATION FORM (ALL FIELDS MUST BE COMPLETE)

### PROOF OF RESIDENCY

*Provide one of the following:*

Driver's License/Permit

Mail with patient name and address

Parents' Drivers License (only for children)

School Report Card (only for children)

Letter Of Support From Supporter (only if above is not applicable, attached)

### PHOTO ID

*Provide one of the following:*

Driver's License/Permit

Passport

Visa/ Green Card/ Any state ID

Birth Certificate (only for children and only if above is not applicable)

### PROOF OF INCOME DOCUMENTS

*Provide one of the following:*

2024 Tax Return

One Month Pay-Stub / Paycheck

Zero Income Statement (attached)

SNAP letter / Unemployment benefit letter / Social Security benefit letter

Employment Termination Letter / VA TANF / Sec on 8 Housing / Pension

Asylum Refugee Status / Student Visa + University Enrollment Letter

Letter From Another Nonprofit Indicating Benefits

Letter Of Support From Parents (only for children)

PATIENT SIGNATURE:

DATE SUBMITTED:

### Options to submit the application and all supporting documents:

1. Email it to [contact@achnhealth.org](mailto:contact@achnhealth.org)

2. Bring or drop a physical copy into the clinic:

4431 Brookfield Corporate Dr, Unit F, Chantilly, VA 20151





# 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, if they are marked "Personal and Confidential."

I understand that I may request in writing that ACHN Clinic restricts 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 with information on how video conferencing technology (telehealth) will be used 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 because 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 in 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 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 emergency 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 Initial:

### ELECTRONIC HEALTH DATA SHARING & FACSIMILE AUTHORIZATION FOR COORDINATION OF CARE

I, the undersigned, authorize ACHN to send/receive confidential healthcare information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act) through approved electronic data share and/or facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care for the patient listed below. Medical records requests require separate form and authorization from this authorization. I may revoke this authorization by giving ACHN five (5) days written notice. This revocation may be by facsimile transmission; however, a written copy of the revocation must be mailed ACHN as well.

**Patient/Guardian Signature:**

**Date :**

**Patient/Guardian's Full Name:**

**Relationship with patient:**



# OFFICE POLICY

**ELIGIBILITY** If you become insured or are insured/have insurance, you are not eligible for our clinic service. Please notify us of any insurance-related changes as soon as possible. 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. Visits are by APPOINTMENT ONLY. We do not accept same day appointments or walk-ins.

**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 for 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 on the next office visit.

**NO SHOWS** If you do not show up to your appointment, you will be charged a \$10 penalty for your next office visit. After 3 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 ACHN Clinic or 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.

**COST** Any labs ordered by ACHN are done at a discounted rate. Lab charges are collected at ACHN. ACHN will not be responsible if labs are done at a facility other than an ACHN approved facility (Sunrise Medical Laboratories). ACHN will help with financial aid applications, however, we are not responsible for any external costs.

**PATIENT PORTAL** All registered patients have access to the patient portal. You may access this patient portal by going to [achnhealth.org](http://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 not to bring your children to your appointment. If you must, they must always stay with you. 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.**

Patient / Guardian Signature:  
Patient / Guardian Full Name :

Date Signed:



# PATIENT HISTORY FORM

Full Name:

Date of Birth:

Reason for Visit:

## ALLERGIES *(Please list all medications, food, or other allergies you may have)*

	<b>Allergen</b>	<b>Severity</b> <i>(mild, moderate, severe)</i>	<b>Reaction</b>
Ex.	Tylenol	Moderate	Hives

## PHARMACY *(Please list your preferred pharmacies for prescriptions)*

Preferred Pharmacy Name:

Pharmacy Address:

## CURRENT MEDICATION *(Please list all medications you are currently taking, including non-prescription drugs or supplements)*

	<b>Medication name</b>	<b>Dose</b>	<b>Frequency</b>
Ex.	Vitamin C	1000 mg	1 tablet twice daily

## FAMILY HISTORY *(Please list history of all diseases or conditions that you have in your family)*

	<b>Disease/ condition</b>	<b>Relatives</b> <i>(father, mother, sibling, other)</i>	<b>Age of onset/diagnosed</b>
Ex	Eczema	Mother & Sister	10 y.o & 5 y.o

## PAST MEDICAL HISTORY *(Please check all medical conditions that you have in the past)*

Diabetes	Eye Disease	Tuberculosis
High Blood Pressure	Heart problems	HIV/AIDS
High Cholesterol	Angina	Stomach or peptic ulcer
Thyroid Disease	Anemia	Kidney Disease
Liver Disease	Asthma	Epilepsy
Cancer	Stroke	Other :

## PAST SURGICAL HISTORY *(Please list all past major surgeries or medical procedures that you have)*

	<b>Surgery</b>	<b>Year</b>	<b>Hospital/Location</b>
Ex	Tonsil surgery	2011	Inova Fairfax, US

**SOCIAL HISTORY**

Do you or have you ever smoked tobacco?

Never Smoke      Former Smoker      Current Everyday Smoker      Current someday Smoker

Do you or have you ever used any other forms of tobacco or nicotine?      Yes      No

What is your level of alcohol consumption?

None      Occasional      Moderate      Heavy

Do you use any illicit or recreational drugs?      Yes      No

What is your level of caffeine consumption?

None      Occasional      Moderate      Heavy

What is the highest grade or level of school you have completed/ highest degree you have received?

*select one*

Attended, no diploma	High School diploma	Bachelor's degree
Some college, no degree	Master's degree	Associates degree
Never attended	Professional degree (MD, DDS)	Doctoral Degree
Do not know		

Are you currently employed?      Yes      No

What is your relationship status?

Single      Married      Divorced      Separated      Widowed      Domestic partner      Other

How many children do you have?

Have there been any changes to your family or social situation?      Yes      No

Do you have any pets?      Yes      No

Do you have smoke and carbon monoxide detectors in your home?      Yes      No

Are you passively exposed to smoke?      Yes      No

Are there any smokers in your house?      Yes      No

Are there any guns present in your home?      Yes      No

Do you use sunscreen routinely?      Yes      No

Are you able to care for yourself?      Yes      No

Are you blind or do you have difficulty seeing?      Yes      No

Are you deaf or do you have serious difficulty hearing?      Yes      No

Do you have difficulty walking or climbing stairs?      Yes      No

Do you have difficulty dressing or bathing?      Yes      No

Do you have difficulty doing errands alone?      Yes      No

Do you have transportation difficulties?      Yes      No

Please select which resources you would like to receive more information on:

Basic needs (food/emergency financial assistance)	Housing / Shelters
Employment and career	Financial education
Senior care	Substance use disorder
Legal support / immigration	Domestic violence



# ZERO INCOME STATEMENT

**To be filled if the patient has no income.  
To be completed by the patient.**

Patient name:

DOB:

I am signing this form to declare that I am currently **UNEMPLOYED** and **DO NOT HAVE ANY INCOME** from any source. I receive financial support from:

**Family, friend, or outside source.**

(Please have your supporter fill out the Letter of Support)

**Receive state benefits.**

This includes but not limited to: SNAP (for food only) / unemployment benefit/ social security benefit/disability benefit/ other states and federal benefits.

(Please submit recent proof of receiving these benefits)

**Other:**

Explain your situation here

I agree to notify the clinic about any changes in my income within 30 days of the change. I understand that by completing, signing, and dating this form, I declare I have no income and that the information I am providing is correct.

Signature of person completing this form (patient)

Date signed



# LETTER OF SUPPORT

**To be filled if the patient is receiving shelter/food/living expense support from someone other than themselves.**

**To be completed by supporter.**

Patient name:

Patient DOB:

Do you (supporter) claim patient as dependent in your current Taxes?      Yes      No

Please select type of support provided (check all that apply):

Shelter:

Move in date:      Move out date:      or      Still living here

Food:

Estimate average monthly support for the patient's food \$

Living expenses:

Average monthly support for the patient's living expenses \$

I expect to provide this support until

Name of person providing support:      Üe|æ1 } • @ Á Á æ2 } dK

Address of person providing support:

Phone number of person providing support:

Email address of person providing support:

**Attestation:**

I certify that to the best of my knowledge, the above information is true and correct. I agree that you may contact me if further verification is necessary.

Signature of person completing this form (supporter)

Date signed