Adams Compassionate Healthcare Network

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-Stubs / 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 **registration@achnhealth.org**

2. Bring or drop a physical copy into the clinic:
   4437 Brookfield Corporate Dr, Suite #109, Chantilly, VA 20151

REGISTRATION FORM

Adams Compassionate Healthcare Network

Are you a new patient?

☐ Yes, I am a new patient. ☐ No, I am returning patient updating my annual eligibility

IDENTIFICATION

Last Name: _____ First Name: _____ Middle Name: _____

Legal Sex: ◯ M ◯ F Date of Birth: _____ SSN: _____

CONTACT

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Select primary number:

◯ Mobile Phone: _____ Consent to receive automated calls? ◯ Yes ◯ No

◯ Home Phone: _____ Consent to receive automated text? ◯ Yes ◯ No

DEMOGRAPHICS

Preferred Language: _____

Race: ◯ Asian ◯ Black ◯ Middle Eastern ◯ White ◯ Other: _____

Are you Hispanic or Latino: ◯ Yes ◯ No

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Seperated ◯ Widowed ◯ Partner

How many people in your household? ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ Other: ____

Select one for household income:

◯ Annually: $ _____

◯ Monthly: $ _____

ADDITIONAL INFORMATION

Is there anyone over 55 years old in your household? ◯ Yes ◯ No

Does anyone have a disability in your household? ◯ Yes ◯ No

Are you a refugee? ◯ Yes ◯ No

Are there any children under 18 in your household? ◯ Yes ◯ No

Country of Origin: _____

Who is the head of your household? ◯ Female ◯ Male

Religion: ◯ Christianity ◯ Hinduism ◯ Islam ◯ Judaism ◯ Other _____

Do you receive any beneýts (SNAP, SSI, Disability, TANT, etc.)?

◯ Yes, if yes specify _____ ◯ No

Is anyone unemployed in your household? ◯ Yes ◯ No

How did you hear about us?

◯ Advertising ◯ Primary care physician ◯ Specialist Physician ◯ Word of mouth

◯ Patient in the practice ◯ Hospital ◯ Insurance company ◯ Other _____

Are you employed? ◯ Yes, place of employment _____ ◯ No

Did you have prior health insurance? ◯ Yes, *If yes specify* ☐ *Medicaid* ◯ No

☐ *Private Insurance*

DISCLOSURE OF PROTECTED HEALTH INFORMATION & EMERGENCY CONTACT

I hereby authorize ACHN Clinic to disclose and discuss information related to my protected health information to/ with the following individuals and the first listed individual will be added as my primary emergency contact:

1. Full name: _____ Relationship to patient: _____ Phone number: _____
2. Full name: _____ Relationship to patient: _____ Phone number: _____

By signing this form, I certify I do not have health insurance and meet the income criteria to receive service in ACHN clinic, all information is true and correct to the best of my knowledge.

Patient/ Guardian Signature: _____ Date _____

Patient/ Guardian Name: _____

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

Adams Compassionate Healthcare Network

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

Adams Compassionate Healthcare Network

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. 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: _____ Date Signed: _____

Patient / Guardian Full Name : _____

Adams Compassionate Healthcare Network

PATIENT HISTORY FORM

Only to be filled by new registaring patient.

Full Name: _____ Date of Birth: _____

Reason for Visit: _____

_____

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

	Allergen	**Severity** (*mild, moderate, severe*)	**Reaction**
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)*

	Medication name	**Dose**	**Frequency**
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)*

	Disease/ condition	**Relatives** *(father, mother, sibling, other)*	**Age of onset/diagnosed**
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)*

	Surgery	**Year**	**Hospital/Location**
Ex	*Tonsil surgery*	*2011*	*Inova Fairoaks, 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

Adams Compassionate Healthcare Network

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: _____ Relationship to patient: _____

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