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# New Patient Application

Today's Date:_____/_____/ _____

Which services are you interested in? ☐ Medical ☐ Dental ☐ Women's Health ☐ Neurology ☐ Pharmacy ☐ MEDAssist ☐ Behavioral Health ☐ Psychiatry

Who would you like to choose as your primary care provider? _____

What pharmacy do you prefer to use? **PATHS Community Pharmacy** ☐ Boydton ☐ Chatham ☐ Danville - Ridge St ☐ Danville – Riverside ☐ Martinsville ☐ South Boston
☐ Other _____

## A. Patient Information

**Name**:_____ **Email**: _____

**Address**:_____**City**:_____**ST**: _____**Zip**: _____
**Do you live in public housing?** ☐ Yes ☐ No ☐ Homeless

**Phone (Home)**:_____-_____-_____ (**Cell**):_____-_____-_____ (**Work**):_____-_____-_____

**Social Security Number**:_____-_____- _____ **Date of Birth**: _____/_____/ _____

**Preferred Language**: ☐ English ☐ Spanish ☐ Other _____ ☐ Interpreter Needed

**Marital Status**: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner

**Accessibility Needs**: ☐ Hearing Impaired/Deaf ☐ Vision Impaired/Blind ☐ Interpreter Needed ☐ None

**Employment Status**: ☐ Employed Full Time ☐ Employed Part-Time ☐ Unemployed ☐ Self Employed Retired
On active military duty

Employer (or Name of School if Minor): _____

**Are you a student?** Yes No If yes, Full-Time Part-Time

**Are you a veteran?** Yes No

**Are you a migrant/seasonal worker?** Yes No

**How do you prefer to be contacted?** Mail Phone Text Email In Person

**I authorize PATHS to leave messages related to my care on my answering machine/voicemail:** ☐ Yes ☐ No

## B. Responsible Party

**Name of Person Responsible for this account**: _____

**Phone (Home)**:_____-_____-_____ (**Cell**):_____-_____-_____ (**Work**):_____-_____-_____

**Relationship to Patient**:_____**Date of Birth**:_____ /____ / _____**SS Number**: ---------- _____

**Address**:_____**City**:_____**ST**: _____**Zip**: _____

Is this person also a patient in another of PATHS services? ☐ Yes ☐ No If yes, which one(s) _____

## C. Insurance Information

***Primary Insurance***

**Name of Insured**: _____ **Relationship to Patient**: _____

**SS Number**:_____-_____-_____ **Subscriber Number:**_____ **Date of Birth**:_____/_____/ _____

**Insurance Company:**_____ **Do you have prescription coverage? ☐ Yes ☐ No**

***Secondary Insurance***

**Name of Insured**:_____ **Relationship to Patient**: _____

**SS Number**:_____-_____-_____ **Subscriber Number:**_____ **Date of Birth**:_____/_____/ _____

**Insurance Company:**_____ **Do you have prescription coverage? ☐ Yes ☐ No**

## D. Parents/Guardians/Physical Custody (Complete for patients 18 years and under)

| **Legal Guardian 1:** | **Legal Guardian 2:** |
|---|---|
| Name: _____ | Name: _____ |
| Relationship:_____ | Relationship: _____ |
| Address:_____ | Address: _____ |
| Phone/Cell: ( _____)_____- _____ | Phone/Cell: ( _____)_____- _____ |

**Who has physical custody of the child?** ☐ Legal Guardian 1 ☐ Legal Guardian 2 ☐ Both

## E. Emergency Contact – (This contact should also be listed on your HIPAA below)

**In the event of an emergency while you are in our office, who should we contact?**

Name:_____ Relationship: _____

Address: _____City: _____ State: _____ ZIP: _____

Phone: (_____)_____- _____ Cell: (_____) _____- _____ Work: (_____ ) _____- _____

## F. Health Record Release Authorization (HIPAA)

**Disclosures to Family & Friends: I authorize disclosures of my health/dental information, relevant to my current treatment to:**

**Name:**_____ **Relationship:** _____ **☐ In Person ☐ By Phone**

**Phone Number:** _____

**Name:**_____ **Relationship:** _____ **☐ In Person ☐ By Phone**

**Phone Number:** _____

**Name:**_____ **Relationship:** _____ **☐ In Person ☐ By Phone**

**Phone Number:** _____

**All-inclusive signature**: _____ **Date:**_____/_____ / _____

***If you want any of your health records released, this page MUST be signed.***

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# Uniform Data System Form

Name_____ Date_____/_____/ _____

## Race

- ☐ Asian
- ☐ Chinese
- ☐ Filipino
- ☐ Other Asian: Please write in race _____
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Unreported/Choose not to disclose race
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ White/Caucasian
- ☐ More than one race

## Ethnicity

- ☐ Hispanic-Mexican, Mexican American, Chicano/a
- ☐ Hispanic-Puerto Rican
- ☐ Another Hispanic, Latino/a or Spanish Origin: Please write in ethnicity _____
- ☐ Not Hispanic, Latino/a, or Spanish Origin
- ☐ Unreported/Choose not to disclose ethnicity

## Birth Sex:

☐ Male ☐ Female

_____

Signature

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## PATIENT MEDICAL INFORMATION

**Name:**_____ **DOB**: _____

**List Medications Currently Using:**

| Name of Medication | Strength | Frequency | Taken When? A.M or P.M | Prescriber | Prescriber Phone Number |
|---|---|---|---|---|---|
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## Please read the following carefully:

I HEREBY AUTHORIZE AND/CERTIFY THE FOLLOWING:

1. Piedmont Access to Health Services, Inc. (PATHS), through its appropriate personnel and/or clinical staff to perform upon, administer to, or prescribe for me, any member of my family (including minor children) whose names appear above such examinations, tests, immunizations, injections, and diagnostic procedures as are deemed necessary. I also certify that all information contained herein is true and correct to the best of my knowledge and belief and that no facts have been omitted.
2. Insurance Authorization and Assignment: PATHS to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for any services rendered by PATHS to myself and my dependents. I understand that I am responsible for any amount not covered by insurance.
3. Medicare Lifetime Authorization: for physical services and request that payment or authorized Medicare benefits be made either to me or on my behalf to PATHS for any services furnished to me by their physicians. I authorize my holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.
4. Deemed Consent for Designated Bloodborne Pathogens: Virginia law requires health care providers to notify you that Hepatitis B and C or HIV (AIDS virus) testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. This following notice is to advise you that this is in effect at this facility. Under the Virginia Acts of Assembly Section 32.1-45.1, whenever any health care worker associated with or working for PATHS is directly exposed to body fluids of a patient in a manner which, according to the guidelines of the Centers for Disease Control, may transmit HIV or Hepatitis B or C, PATHS will proceed to test the patient's blood for HIV and Hepatitis B and C. PATHS will provide the results of the test to the patient through his or her primary care provider and to the health care worker who was exposed. PATHS' policy also protects you as a patient, should you be exposed to the body fluids of a health care worker.
5. Private Health Information: I certify that I have been informed of the policies and procedures related to how PATHS may use and/or disclose my personal health information.
6. I give my MEDAssist Case Worker the authority to contact my physician(s) and exchange any necessary information in order to apply for free medications. I also give my MEDAssist Case Worker the authority to exchange information with the pharmaceutical companies that manufacture my medications in an effort to access free medication.
7. I authorize my MEDAssist Caseworker to sign any necessary forms on my behalf when ordering medications for me. I understand that this will speed up the ordering process. This signature authorization is valid as long as I am receiving services thorough MEDAssist.
8. Your signature below authorizes PATHS to obtain your records from SOVAH Health - Danville, SOVAH Health – Martinsville, Sentara Halifax Regional Hospital and VCU Health Community Memorial Hospital for the purpose of continuity of care.
9. Consent to Obtain External Prescription History/E-Prescribing Consent: By authorizing PATHS, you allow us to view your external prescription history via a prescription monitoring service. This will provide the physician with information about medications the patient is already taking to minimize the number of adverse drug effects. By signing this form, you are agreeing that you understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my provider and staff here, and it may include prescriptions back in time for several years. By signing this form, you are agreeing that PATHS can request and use your prescription history from other healthcare providers and/or third part benefit payers for treatment purposes.

**The information provided on this registration form is true, accurate, and complete to the best of my knowledge.**

All inclusive signature:_____ Date:_____/_____/ _____

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## POLICIES THAT MAY AFFECT YOU

***PATHS is working hard to make sure that all our patients have access to the highest quality care possible. We want to make sure that you are well informed of the policies we have implemented that will help make that possible.***

1. **Phone Calls:** We are committing to you as a patient, that anytime you call our office, your questions will either be answered immediately, or if it's necessary to leave a message, we will return your call within one business day.
2. **Medication Refill Requests:** Please help us manage your medication needs by allowing enough time before running out of your medication. Please contact your pharmacy to request a refill. Your provider at PATHS will be notified electronically. **This process may take up to three business days.**
3. **Appointment Times:** We will do our best to provide you with an appointment at a time that is convenient for you. We ask that you arrive 15 minutes before your appointment to update your personal information and insurance. If you are more than 10 minutes late arriving for your appointment, we may have to reschedule your appointment.
4. "**No Show" Appointments:** A no-show is defined as the client failing to keep a scheduled appointment with a PATHS provider without prior notification of the need to cancel. Exceptions will be made for circumstances beyond the control of the client, such as family emergencies, extreme illnesses, death in the family, or transportation difficulties. In this case, the client should make every effort to notify appropriate PATHS office of the reason for the missed appointment as soon as possible.

   All appointments have a 10-minute late window. If you arrive more than 10 minutes late to your appointment time, it is considered a "No Show." When a patient "No-Shows" for appointments repeatedly, PATHS will take the following steps based on the service type:

   - **All Medical Services:** If a no-show happens five times in a twelve-month period, we will ask that you take advantage of our walk-in access system for six months. This means that you will not be able to schedule an appointment at a particular time, but can come in, register, and wait. Our staff will make every effort to work you in to be seen.
   - **Behavioral Health/Psychiatry:** If a no-show happens three times in a three-month period, we will ask that you take advantage of our walk-in access system for six months. This means that you will not be able to schedule an appointment at a particular time, but can come in, register, and wait. Our staff will make every effort to work you in to be seen.
   - **Dental:** If a no-show happens three times in a twelve-month period, the patient will be sent a letter of dismissal at their last known address. The letter will include a list of providers the patient may qualify for and will be seen at PATHS for the next 30 days for emergency care only.
5. **Sliding Fee Scale:** PATHS offers a sliding fee scale based on gross household income which may allow us to reduce the fees/copays of those who qualify. All patients (with or without insurance) may apply for the Sliding Fee Scale. In order to apply, you will need to provide proof of income for everyone in your household. You do not have to apply for sliding fee scale, however, you will be responsible for 100% of our routine charges until you do. If you choose to apply and are approved, you will need to reapply once a year.
6. **Narcotic Prescription Medications:** As a rule, PATHS providers will not write prescriptions for pain pills, Xanax-type drugs, or other controlled substances.
7. **Collection Policy:** PATHS is committed to providing access to care for everyone in our community regardless of their ability to pay. This is accomplished by providing the opportunity for you to apply for the sliding fee scale. From that point, it is important that you clearly understand the importance of meeting your financial obligations as they relate to your care at PATHS. If you do not pay your bills on time and are unwilling to set up a payment plan, PATHS may refer your account to a third-party agency for assistance in collecting. Continued unwillingness to pay may leave us with no choice other than to discharge you. If you are concerned that this may affect you, please see a member of our staff, or call our office for assistance immediately to avoid being discharged.
8. **PCMH:** I understand that PATHS will be my "Patient Centered Medical Home." I have been given information as to what this means to PATHS, and acknowledge understanding of what is expected of me.

Signature: _____ Date:_____/_____/ _____

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# SLIDING FEE SCALE APPLICATION

**If you do not wish to apply for the discount, please initial here: _____**

Head of Household (Printed):_____Date:_____ /_____ / _____

Date of Birth:_____/_____ / _____ **Do you file taxes? ☐ Yes ☐ No**

How many in your household are dependent on this income?_____ (include yourself)

Please complete the following: You must list ALL members of your tax household, including yourself. This includes age, relationship to applicant, and ALL sources of income. (Wages, child support, social security, pension, disability, unemployment, etc.). IF A HOUSEHOLD MEMBER DOES NOT HAVE INCOME, PUT $0.00 IN THE INCOME BOX FOR THAT MEMBER.

| Name | Age | Relationship | Income | Pay Period |
|---|---|---|---|---|
| | | | | ☐ Bi-weekly ☐ Twice Monthly ☐ Monthly ☐ Weekly ☐ Annually |
| | | | | ☐ Bi-weekly ☐ Twice Monthly ☐ Monthly ☐ Weekly ☐ Annually |
| | | | | ☐ Bi-weekly ☐ Twice Monthly ☐ Monthly ☐ Weekly ☐ Annually |
| | | | | ☐ Bi-weekly ☐ Twice Monthly ☐ Monthly ☐ Weekly ☐ Annually |
| | | | | ☐ Bi-weekly ☐ Twice Monthly ☐ Monthly ☐ Weekly ☐ Annually |
| | | | | ☐ Bi-weekly ☐ Twice Monthly ☐ Monthly ☐ Weekly ☐ Annually |

(BI-WEEKLY IS GETTING PAID EVERY 2 WEEKS, TWICE MONTHLY MEANS 2 PAYCHECKS PER MONTH, ON THE SAME DATE EACH MONTH)

Place of employment: _____

If you are unemployed, how long? _____

How many hours per week do you work on average? _____ What is your rate of pay? _____

Does anyone in the household receive Disability, Social Security, or Pension income? ☐ Yes ☐ No

Disability $_____ Social Security: $_____ Pension $_____

The information provided concerning the size of my family and my family's gross annual income from all sources is true, accurate, and complete to the best of my knowledge. I realize that PATHS Community Medical/Dental Center will rely on such information to determine how much my account will be discounted. I realize that knowingly giving false information in this case may result in criminal prosecution under the laws of Virginia. I agree to report any change in either my income or my family size to PATHS. PATHS may initiate a review of my payment status at any time to verify the information I have provided.

**Signature:**_____ **Date:** ____ / ___ / _____

**For Front Desk Use Only:**

**Sliding Scale Type**: _____ **Sliding Fee Scale Expiration Date**:_____/_____/_____**Initial**: _____

This document contains information pertaining to policies and procedures that apply to how PATHS operates in terms of providing your health care. If you have questions about anything you read, please ask our staff during your appointment, or you may contact us by phone.

**PRIVACY PRACTICES/HIPAA POLICIES:**
This notice describes how health information about you may be used and disclosed and how you can get access to this information. If you have any questions about this notice, please contact PATHS HIPAA Officer.

Though your health record is the physical property of the facility that compiles it, you have the right to the following upon written request:

- Inspect and Copy: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain, very unique, circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by PATHS will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- Amendments: If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by PATHS. We may deny your request for an amendment, but if this occurs, you will be notified of the reason for the denial.
- Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment, or health care operations.
- Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care for the payment of your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure you had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
- Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you at work or by US Mail. Please realize we reserve the right to contact you by other means and other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

To exercise any of your rights, please obtain the required forms from the HIPAA Officer, Robert Thurman
(Phone) 434.791.3630 x1015, and submit your request in writing.

- *Changes to this Notice:* We reserve the right to change this notice, and the revised or changed notice will be effective for information we already have about you, as well as any information we receive in the future. The current notice will be posted in all PATHS locations and will include the effective date. In addition, each time you register at our facility for treatment or health care services, updated copies of this notice will be available by request.

- *Complaints:* If you believe your privacy rights have been violated, you may file a complaint with the Department of Health and Human Services or PATHS by contacting the main number and asking for the HIPAA Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

- *Other Uses of Health Information:* Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose Health Information about you, you may revoke your permission. We will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission. We are required to retain records of your care.

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## Welcome to your medical home!

Patient centered is PATHS way of saying that you, the patient, are the most important person in the health care system. You are at the center of your health care. A medical home is an approach to providing total health care. Caring for you when you are well physicals and preventive screenings, and when you are sick (acute-i.e. sore throat, cold) or have on-going health concerns (chronic-i.e. high blood pressure, diabetes). We will even see that you get the care that you need if we don't have the skills to meet your need (specialty care i.e. diagnostic testing or specialists like neurology).
With your medical home at PATHS, you will join a team that includes health care professionals, trusted friends or family (if you choose), and-most importantly-you. The health care system can be confusing, and a lot of people can start feeling lost in the system after visiting several doctors. The medical home team will listen to your questions and can help you find your way through the system.

**A. What PATHS medical home will do for you:**

1. Your medical home team will know you and your family and can provide you with total health care. You will see the same team each time you visit, and they can help answer your health questions.
2. We will track your care using computers and electronic records so that all of your records will be in one place.
3. You will be able to reach your team when you need them:
   - **During regular office hours that include extended hours:**
     - **Boydton:** (Phone) 434.738.6420 (Fax) 434.738.6054
       (Day/Hours) Monday, Thursday, Friday 8:00 to 5:00; Tuesday & Wednesday 8:00 to 8:00
     - **Chatham:** (Phone) 434.432.4443 (Fax) 434.432.3555
       (Day/Hours) Monday-Thursday 8:00 to 6:00; Friday 8:00 to 5:00
     - **Danville "Riverside":** (Phone) 434.791.4122 (Fax) 434.791.4126
     - (Day/Hours) Monday-Thursday 8:00 to 6:00; Friday 8:00 to 5:00
       **Danville "705 Main St":** (Phone) 434.791.4122 (Fax) 434.791.4126
       (Day/Hours) Monday, Tuesday and Wednesday 8:00 to 6:00; Thursday 8:00 to 7:00; Friday 8:00 to 5:00
     - **George Washington High School:** (Phone) 434.791.0216 (Fax) 434.791.2191
       (Day/Hours) Monday-Friday 8:00 to 5:00
     - **Martinsville:** (Phone) 276.632.2966 (Fax) 276.632.0841
       (Day/Hours) Monday-Thursday 8:00 to 6:00; Friday 8:00 to 5:00
     - **Rison Street Dental**: (Phone) 434.791.0214 (Fax) 434.791.0217
       (Day/Hours) Monday – Friday 8:00 to 5:00
     - **South Boston:** (Phone) 434.575.1336 (Fax) 434.575.1349
       (Day/Hours) Monday – Thursday 8:00 to 6:00; Friday 8:00 to 5:00
   - **Access to Providers After Hours:**
     - We understand that sometimes you may need to contact your healthcare provider outside of regular office hours. Due to this, we offer our patients after-hours communication. You may contact the provider on-call after hours by calling the main number at any of our PATHS locations.
     - **Patient Portal:** https://mycw10.eclinicalweb.com/portal422/jsp/login.jsp.
     - If you have access to a computer or cellular phone with the internet; you will have access to your health information 24/7. Safe, secure, and just for you.
4. PATHS medical home will be the coordinator of all your care—the one place where you can learn about and have access to information about your medications, visits to specialist, medical history, health status, recent tests, self-care information, information from recent hospitalizations, specialty care or ER visits. PATHS can be your store house or go to place for every aspect of your care—a one stop shop if you will.

**B. With a medical home you and your team work together. It is not a passive or one-sided relationship.**

1. You will have a chance to explain things that are important to you.
2. You will have your questions answered in a way that will help you better understand your health needs.
3. If you need help from other doctors your PATHS medical team will support you every step of the way.
4. You will have convenient office hours to help you get an appointment that suits you.

**C. Together, you and your team can work out a plan just for you, including:**

1. Personalized health care that meets your needs.
2. Tracking of your care.
3. Many ways to keep in touch with your health care team.

Commit to your PATHS medical home team by contracting with them to be a team participant as they commit to you by being your personalized medical home, providing you with all the things discussed as well as a quality, evidenced-based care, and support for your own self-management of your health and health care needs.

Working with your team may improve the quality of health care and shorten the time it takes to get that care. Remember, the medical home can be a way for you to be informed about and involved in your health care decisions. The medical home can bring you, your family, and your health care team together to help you make the best choice about your health.