

REDUCED FEE PROGRAM

Johnson Health Center's mission is to improve access to healthcare for all. One of the many barriers to individuals receiving healthcare is the inability to pay for services. At JHC, we offer a reduced fee program for patients who do not have insurance or whose insurance has high deductibles or does not cover certain services.

If you are experiencing difficulty affording healthcare, you can stop by any of our locations to pick up an application for our reduced fee program or download the application below. With our streamlined application process, you will have the opportunity to apply for reduced fee services at multiple locations (such as medical and dental) with the convenience of using just one form.

Once you have completed the forms and provided the required documentation, you will be assigned a fee schedule within 2 business days. With our reduced fee program, you will have the opportunity to receive health care at an affordable rate without sacrificing quality of care!

Call **(434) 929-1400**
Or [Find My Location](#)

QUICK LINKS

- Careers
- Patient Portal
- Topic of the Month
- Become a Patient
- Privacy Policy
- Accessibility

Johnson Health Center is a 501(c)(3) non-profit organization.

JHC is a Federally Qualified Health Center (FQHC) and has malpractice coverage under the Federal Tort Claims Act (FTCA).

Stay in Touch

Connect with us and sign up for Johnson Health News and Updates.

Copyright © 2020 Johnson Health Center, All rights reserved.

SITE BY **434** MARKETING



PATIENT REGISTRATION FORM

Patient Information

First Name: _____ M.I.: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
D.O.B.: _____

Identify person filling out form (circle one): Self/Patient Parent/Guardian (name): _____

Contact Information (If patient is a minor, use parent/legal guardian contact info.)

Email: _____
Home phone: _____ Cell: _____ Work phone: _____

Circle answers below with patient information, not parent/legal guardian info, if patient is a minor.

Marital Status: Single Married Divorced Widowed

Sexual Orientation: Straight Lesbian or Gay Bisexual Something else Don't know Choose not to disclose

Gender: Male Female Transgender, Male-to-Female Transgender, Female-to-Male Other Choose not to disclose

Preferred Language: English Spanish Korean Other

Ethnicity: Hispanic Non-Hispanic
Race: Black/African American White Native Hawaiian Other Pacific Islander Native American/ Native Alaskan Asian More than one race

Employment Status: Full-time Part-time Self-employed Non-employed Retired Active Military

Are you currently a student? Yes No Are you a veteran? Yes No

Insurance: Medicaid Medicare/Medicaid QMB Private Insurance I do not have insurance I do not have prescription coverage

How did you find out about JHC? (check):

- Prior experience with Johnson Health Center
Referral (from Free Clinic, Social Services, etc.)
Word of mouth (friend, family)
Internet (Facebook, website)
Outreach event (health event, craft fair, etc.)
Newspaper (article, advertisement)
Television

Guarantor/Responsible Party Information (If different from patient information above.)

First Name: _____ M.I.: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
D.O.B.: _____ Relationship to patient: _____
Email: _____
Home phone: _____ Cell: _____ Work phone: _____

AUTHORIZATION FOR TREATMENT

I consent for Johnson Health Center's appropriate personnel and/or clinical staff to perform acute, chronic, and/or emergency medical treatment and preventative, health maintenance, and/or behavioral/mental health care as deemed medically necessary. (If the named individual on other side of this page is a minor at the time of consent, a parent or legal guardian must sign this consent for treatment). A "Behavioral Health Consultant" is a member of the primary care team that works closely with your medical provider to recognize and address medical conditions associated with acute and chronic mental and emotional disordered conditions. There is only one electronic health record used between primary care team members in addressing your treatment plan of care and this health information is shared between these primary care team members.

AUTHORIZATION FOR PAYMENT

I authorize the release of any and all medical information necessary to process my insurance claims. I permit a copy of the authorization to be used in place of the original. I authorize Johnson Health Center to file my insurance for services rendered. I request that payment be made directly to Johnson Health Center. I certify that the information that I have reported with regard to my insurance coverage and my personal information is correct. I understand that claims may be filed electronically through a safety net Internet portal. I understand that I am responsible for any and all balances that my insurance company does not pay.

AUTHORIZATION TO LEAVE MESSAGES

If we are unable to contact you and you have an answering machine or voicemail, do we have your permission to leave a message containing medical information (circle appropriate): **YES** **NO**

If Yes, where may we leave messages (circle appropriate): **HOME** **CELL** **WORK**

NOTICE OF PRIVACY PRACTICES

Initials _____ I have received and read the Notice of Privacy Practices from Johnson Health Center.
Date _____

PATIENT RIGHTS & RESPONSIBILITIES

Initials _____ I have received a copy of the Patient Rights & Responsibilities and had an opportunity to ask question regarding them.
Date _____

MEDICATION POLICY

Initials _____ I understand that Johnson Health Center will access the Virginia Prescription Monitoring Program to verify medication use and to avoid medication interactions.
Date _____

Patient Signature (Parent/Guardian if minor) _____

Date: _____

(This consent form will be used as needed and you may revoke or change any of the above consents at any time)

Members of the Household

You must list ALL members of the household, including yourself. This includes age, relationship to applicant, type of insurance, and ALL sources of income. (Wages, child support, disability, social security, SNAP, etc.)

Name	Age	Relationship	Income	Type of Insurance

Household Income

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? _____

Pay period: Bi Weekly Twice Monthly Monthly Weekly

Does anyone in the household receive Disability, Social Security, or Pension income? (Please circle):
 Yes No

If there is more than one person receiving any of these benefits, please specify _____

Amount: Disability _____ Social Security _____ Pension _____

Primary Medical Insurance Information

Insurance: _____

Name of insured: _____

Insured's _____

Relationship to patient: _____

D.O.B.: _____

Group number: _____

Effective date: _____

Policy number: _____

Secondary Medical Insurance Information

Insurance: _____

Name of insured: _____

Insured's D.O.B.: _____

Relationship to patient: _____

Group number: _____

Effective date: _____

Policy number: _____

Spouse or Emergency Contact Information

Full name: _____

Address: _____

City: _____

State: _____

Zip: _____

(Phones) Home: _____

Cell: _____

Work: _____

What is JHC Reduced Fee?

As a Federally Qualified Health Center, Johnson Health Center does not discriminate based upon a patient's ability to pay. JHC offers to all patients the opportunity to apply for the Reduced Fee program.

Reduced Fee eligibility is determined using family size, household income, and the Federal Poverty Guidelines as updated annually by the Department of Health and Human Services. Federal Poverty Levels are determined annually as part of the Federal Poverty Guidelines.

Reduced Fee Release of Information

I, the undersigned, attest to the accuracy and truth of the information provided within this application for services. Johnson Health Center staff may verify all information provided.

I authorize the release of information to Johnson Health Center Medication Assistance Program and the sharing of information about my application to other agencies, pharmaceutical companies, and physicians.

I understand that any changes in income and household must be reported to the Reduced Fee Coordinator as soon as possible. I will also report changes in address and phone number.

I understand that it is my responsibility to provide documentation and update my application every year or otherwise, if deemed necessary, in order to remain an active patient at Johnson Health Center and its participating agencies.

I, the undersigned, verify that the information provided as part of the Johnson Health Center Sliding Fee Application is true and accurate. If the information is determined to be false and misleading, I understand that the Johnson Health Center has the right to discontinue my sliding fee rate and I will pay the full fee.

This release expires in one year.

Printed Name: _____

Signature: _____

Date: _____

Medication Assistance Program (MAP)

The MAP is specifically designed to help those who are currently without prescription coverage needing assistance with their maintenance medications. JHC staff coordinates with the pharmaceutical companies to access medicine on your behalf. There is a fee of \$5.00 for every medicine received and this can be paid by cash, check or credit card.

An application is needed for each medication. Your signature is required to process the application with the appropriate pharmaceutical company. **It can take up to 4 to 6 weeks to start receiving your medications.** If you have questions about the MAP, please contact the MAP Coordinator at (434)947-5967 ext. 1243 or ask to speak to Kelly McConnell after your appointment with your provider.

Checklist

In order to complete applications, you will need to turn in ALL documentation of income. All documentation needs to be from the current year. This may include, but is not limited to, any items that pertain to you on this list:

- Last month's pay stubs: must be consecutive and a full month
- Current year tax return 1040 for or schedule C if self-employed
- 4506T if you do not file taxes
- Child support documentation
- Unemployment award letter
- Pension or retirement award letter
- TANF award letter
- Food stamps award letter
- General relief award letter
- Letter of support

Please speak with your provider or contact Kelly McConnell
at (434)947-5967 ext. 1243 for more MAP information.

This Page for Office Use Only

Family Size: _____

Income: _____

After examination of this applicant's family size, situation, and financial information, it is my decision that this application is:

- Approved at the rate of:
 A B C D
- Approved for OB Prenatal with a total cost of _____
- For children under age 18; ineligible for Medicaid:
- Does not meet citizenship or immigration status requirements
- Other: _____
- Denied, Reason: _____

For the Following Program(s):

- Adult Medical Services
- Pediatric Medical Services
- OB/Prenatal/Gyn Services
- Dental Services
- Behavioral Health Services
- Medication Assistance Program (MAP)

This status shall remain in effect from _____ to _____ unless otherwise noted, at which time the applicant's financial situation will be reviewed to evaluate eligibility and classification.

Comments:

Reduced Fee Coordinator _____ Date _____

This Page for Office Use Only

Page 1

Patient Information

Comments:

Guarantor/Responsible Party

Comments:

Page 2

Members of the Household

Comments:

Household Income

Comments:

Primary Medical Insurance Information

Comments:

Secondary Medical Insurance Information

Comments: _____

Emergency Contact

Page 3

Authorization for Treatment

Patient Declined

Authorization for Payment

Patient Declined

The patient made aware that declination means the he/she will receive a bill for all services provided?

Yes or No

Authorization to Leave Messages

Patient Declined

Notice of Privacy Practices

Patient Declined

Patient Rights & Responsibilities

Patient Declined

Pages 4 & 5

Reduced Fee Release of Information & Reduced Fee

Comments:
