2822 Jackson Blvd, Suite 101
Rapid City, South Dakota 57702
605.341.1208 (office) 605.341.3552 (fax)
www.creeksidemedicalclinic.org

Patient Registration Form

Patient Information *(please print)* — Account Number:

Last Name:	**First Name** *(legal)*:	**M.I.:**	**Preferred Name:**
Mailing Address:		**City/State/Zip:**	
Cell Phone: **OK to Leave Message?** ☐Yes ☐No	**Home Phone:** **OK to Leave Message?** ☐Yes ☐No	**Work Phone w/ext:** **OK to Leave Message?** ☐Yes ☐No	
Date of Birth:	**Social Security Number:**	**Sex:** ☐Male ☐Female	**Email Address:**
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Domestic Partnership	**Employer:**	**Employer Phone:**	
Emergency Contact Name:	**Relationship to Patient:**	**Phone Number:**	
Race: ☐White ☐American Indian or Alaskan Native ☐Asian ☐Hispanic ☐Black or African American ☐Hawaiian or Pacific Islander ☐Other ☐Decline		**Ethnicity:** ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline	

SECTION 2: Responsible Party *(if different than patient)*

Last Name:	**First Name** *(legal)*:	**M.I.:**	**Relationship to Patient:**
Mailing Address *(if different than patient's)*:		**City/State/Zip:**	
Phone Number:	**Date of Birth:**	**Social Security Number:**	

MUST COMPLETE: **Primary Medical Insurance**	**Secondary Medical Insurance**
Ins. Co. Name:	Ins. Co. Name:
Policy Holder's Name:	Policy Holder's Name:
Policy Holder's DOB:	Policy Holder's DOB:
Policy Holder's Social Security Number:	Policy Holder's Social Security Number:
Policy Holder's Relationship to Patient:	Policy Holder's Relationship to Patient:

SECTION 3: Assignment of Benefits • Release of Information • Financial Responsibility

I hereby assign all medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Creekside Medical Clinic (CMC). I further authorize assignee to obtain my plan provisions under ERISA and to act as an authorized representative on my behalf on insurance claims. This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I authorize the use of this signature on all my insurance and/or employee health benefits submissions. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I hereby authorize said assignee to release all information, including medical record copies necessary to secure payment and to complete disability forms presented to me. In response to any reasonable request for cooperation, I agree to cooperate with CMC in any attempts by CMC to pursue such claims(s) chosen in action or right against my insurers and/or employee healthcare plan.

Certain physicians (e.g. pathologists, laboratories, and radiologist) may interpret my test results. These physicians may not be employees or agents of Creekside Medical Clinic and I may therefore receive separate bills from these physicians for their services. I may also receive separate charges on subsequent days from the physicians for these services. The undersigned authorizes these physicians to bill me and/or my insurance(s) for these services and receive any direct payment from any insurance benefit. A $30 plus tax service charge will be assessed against all non-sufficient funds/closed account checks. I have read and fully understand this agreement.

Printed Name of Patient ______________________ Printed Name of Parent or Legal Guardian (if applicable) ______________________

Signature of Patient, Parent, or Legal Guardian ______________________ Date Signed ______________________

SECTION 4: HIPAA Privacy Authorization to Individuals

As required by the Health Insurance Portability and Accountability Act of 1996, Creekside Medical Clinic may not use or disclose your health information to anyone without your authorization, except as provided in our Notice of Privacy Practice. Your signature on the following section indicates that you are giving permission for the uses and disclosures described herein. You may revoke this authorization at any time by completing a new authorization. **If you wish to authorize no one, please skip this section and refer to SECTION 6.**

I, ____ *(printed name of patient or minor child)*, hereby authorize Creekside Medical Clinic to use and/or disclose my complete protected health information, including billing matters, conditions, treatments, prognosis, as well as mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse to the following individual(s).

Name *(please print)*	Relationship	Phone Number

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties by the authorized individuals above and is therefore no longer protected. I understand that this authorization will automatically expire on December 31, 2020, but I may revoke this authorization at any time by completing a new registration form and returning it to Creekside Medical Clinic. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization. I understand that I am under no obligation to sign this authorization, and that my ability to obtain treatment will not depend on whether I sign this authorization or not.

______________________________________ Signature of Patient, Parent, or Legal Guardian

______________________________________ Date Signed

SECTION 5: Consent for Medical Treatment of a Minor

As a parent/guardian to ____*(printed name of minor child)*, a minor, I am authorizing the following:

____________***(please initial)*** to be seen **without** a parent or guardian present.

____________***(please initial)*** to be seen and treated at CMC without a parent, **only** when accompanied by the following adult family member or friend.

Name of Authorized Individual *(please print)*	Relationship to Patient

I further understand that this authorizes Creekside Medical Clinic to provide medical and/or billing information to various laboratories, radiology facilities, etc. for tests that may become necessary for treatment. I accept responsibility for all physician, laboratory, radiology charges, or other related fees. This authorization will remain in effect until revoked by me, or when the minor patient reaches 18 years of age.

______________________________________ Name of Patient

______________________________________ Printed Name of Parent or Legal Guardian

______________________________________ Signature of Parent or Legal Guardian

______________________________________ Date Signed

SECTION 6: HIPAA Privacy Authorization to Individuals Waiver

I **do not** wish to authorize the use and disclosure of my (or my minor child's) health information to anyone but me.

______________________________________ Printed Name of Patient

______________________________________ Printed Name of Parent or Guardian (if applicable)

______________________________________ Signature of Patient, Parent, or Legal Guardian

______________________________________ Date Signed