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:	Maiden Name *(if applicable)*:

Mailing Address:	☐Apt. ☐Lot ☐Ste.	City:	State:	Zip:

Primary Phone: ☐Mobile ☐Home ☐Other	Secondary Phone: ☐Mobile ☐Home ☐Other	Work Phone: Voicemail OK? ☐Yes ☐No Ext. 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.	Maiden Name *(if applicable)*:	Relationship to Patient:

Mailing Address *(if different than patient's)*:	Apt or Lot:	City:	State:	Zip:

Date of Birth:	Phone Number:	Social Security Number:	Employer:

MUST COMPLETE *(if policy holder is different than patient)*: 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.

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
Name *(please print)*	Relationship	Phone Number
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, 2029, but I may revoke this authorization at any time by completing an *Update Authorizations & Disclosures* 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 or not I sign this authorization.

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(s) or friend(s):

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

I understand that I am authorizing 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 financial responsibility for all physician, laboratory, radiology charges, or other related fees. I further understand that I may revoke this authorization at any time by completing an *Update Authorizations & Disclosures* form, and that this authorization expires when the minor patient reaches 18 years of age.

Signature of Parent or Legal Guardian	Date Signed

Patient Name:	Account Number:

Your Medical History

Medical Conditions:

Previous Surgeries:

Current Medications:

Name	Dose	Directions (how often)

Do you have medication allergies? ☐ **Yes** ☐ **No** If yes, indicate below:

Preferred Pharmacy: _____

Do you smoke? ☐ **Yes** ☐ **No** If yes, how much? _____

Do you drink alcohol? ☐ **Yes** ☐ **No** If yes, indicate how much:

☐ **Daily** ☐ **Weekly** ☐ **Monthly** ☐ **Less than Monthly**

Family Medical History

If parent(s) are deceased, please indicate age(s) and cause(s) of death.

Mother?

Cause of Death Age

Father?

Cause of Death Age

In the spaces provided, please indicate who in your family has been diagnosed with the following medical conditions:

Arthritis?

Relationship

Autoimmune Disease?
(Rheumatoid Arthritis, Lupus, etc.)

Relationship Type

Relationship Type

Heartburn or GERD?

Relationship

Osteoporosis?

Relationship

Heart Disease?

Relationship

Hypertension?

Relationship

Diabetes?

Relationship

Cancer?

Relationship Type

Relationship Type

Relationship Type

Other Medical Conditions?

Relationship Type

Relationship Type

Relationship Type

Acct Number:

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

Understanding Your Annual Preventative Health Services

Dear Patient,

Our goal at Creekside Medical Clinic (CMC) is to provide you with the best medical care possible. Annual physicals or preventative visits give our providers a chance to address your overall physical and emotional wellness. The preventative care we provide during your annual physical may include (but is not limited to) a discussion of your exercise and dietary habits, lifestyle behaviors, screening labs, as well as current medications and vaccinations. We often review chronic but well-controlled medical conditions during your annual physical, i.e., high blood pressure, arthritis, diabetes, etc. Though reviewing these conditions can sometimes be included in a preventative visit, depending on the degree of difficulty or the amount of time spent, a regular office fee in addition to your preventative visit may be charged.

Regular office visits differ from preventative care in that your provider will address either new-onset, or other chronic medical conditions, or both. These types of problems need to be addressed in an appointment separate from a preventative exam. If, however, your preventative services have been adequately covered during your scheduled physical, and if there is extra time available, you may be able to address other concerns with your provider.

We are attempting to correct a possible misperception that at times we have or will "double charge" you for our services. Insurance carriers do allow providers to address additional complaints beyond your physical examination if there is time to do so. For example, if problems are found or addressed during your physical, a non-preventative office evaluation code will be generated in addition to a preventative examination office code. Because of the extra office code, your insurance may require you to pay an additional copay, coinsurance, or deductible. A preventative visit may also be changed to an office visit based on the conditions being treated or discussed. *In other words, during your scheduled physical exam, your provider may determine that the reason why you are being seen does not fall within the definition of preventative care and its corresponding coding rules.*

The coding guidelines set forth by the American Medical Association specifically state, "If an abnormality is encountered or a pre-existing problem is addressed in the process of performing this preventative medicine evaluation and management service, (…) then the appropriate Office/Outpatient code should also be reported" (*Current Procedural Terminology*, 2016). It is important for our patients to understand that **we at CMC can fail audits if we violate these coding rules**. You and others like you have entrusted us with your medical care. Please also trust that we practice integrity with our billing practices as well. Our goal is to provide excellent care and take the appropriate time in doing so. Please speak with your provider if you have any questions regarding your preventative care charges today.

Sincerely,

Your Providers at
Creekside Medical Clinic

I have read the Physical Exam & Office Visit letter and understand that I may be billed an additional charge by my insurance company. This charge may be a copay, coinsurance, or deductible, and I will be responsible for payment of this additional charge.

Name of Patient _____ DOB _____

Signature of Patient or Guardian _____ Date _____

****Please let us know if you would like a copy of this agreement for your records****

CPT 2016 Professional Edition. (2015). Chicago, IL: American Medical Association, p. 37

Consent For the Use and Disclosure of Protected Health Information

I hereby consent to the use and disclosure of my protected health information by Creekside Medical Clinic staff and their business associates for purposes of **treatment**, various activities associated with **payment,** and **healthcare operations**. I understand that protected health information is individually identifiable (e.g., name, social security number, date of birth).

I understand that uses and disclosures of my protected health information for treatment, payment, and healthcare operations include, but are not limited to the following:

- Using or disclosing health information in order to make a diagnosis or provide treatment to me
- Submitting health information to health insurance companies in order to obtain payment for treatment or services rendered
- Sharing health information with other healthcare providers with which I have a treatment relationship
- Review my health information during quality assessment activities and training of medical personnel

I understand that I may request a more detailed explanation of Creekside Medical Clinic's privacy practices prior to signing this consent. I also understand that the terms of the *HIPAA Notice of Privacy Practices* may change and that I may request a revised notice by contacting Creekside Medical Clinic.

I understand that I have the right to request that the provider restrict how it uses and discloses my protected health information in order to carry out treatment, payment, or healthcare operations. I understand that the provider is not required to agree to the restrictions, but that if the provider agrees, the restriction is binding.

I understand that I have a right to revoke this consent, but I must do so in writing. I understand that a revocation applies to the provider's use and disclosures made after the revocation is made. I also understand that if I revoke this consent, I may be denied treatment.

Patient Name *(please print)*	Name of Parent or Legal Guardian
Signature of Patient, Parent, or Legal Guardian	Date Signed

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