CREEKSIDE MEDICAL CLINIC

2822 Jackson Blvd., Suite 101
Rapid City, South Dakota 57702
Telephone (605) 341-1208 • Fax (605) 341-3552
www.CreeksideMedicalClinic.org

Patient Registration Form

Account # _____

Patient Information

Last Name:	First Name (Use legal name not nickname):	M.I.:	Preferred Name

Address:	City/State/Zip:
Cell Phone:	Home Phone:	Work Phone w/ext:
Social Security #:	**Date of Birth:**	Sex: ☐ Male ☐ Female
Previous Name (If applicable) (Maiden Name)	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow
Employer Name:	Employer Phone:
Emergency Contact:	Phone:	Relationship to Patient:

Responsible Party

Person responsible for the bill (Only if different than Patient): Last:	First:	M.I.:
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:	City, State, Zip:
Employer of Person Responsible:	Relationship to Patient:

Insurance & Payment Info

MUST COMPLETE: Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name:
Policy Holder's Name:	Policy Holder's Name:
Effective Date:	Effective Date:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Policy Holder's Relationship to Patient:	Policy Holder's Relationship to Patient:
Employer Name:	Employer Name:

Additional Information

Email Address:	Can we leave a message regarding your medical care, test results & appointment reminders? ☐ No ☐ Yes If yes: ☐ Brief ☐ Extended ☐ Home ☐ Cell

Race (please select one): ☐ White ☐ Native American or Alaska Native ☐ Asian ☐ Black or African American ☐ Hawaiian or Pacific Islander ☐ Hispanic ☐ Other ☐ Decline

Ethnicity (please select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Preferred Language (please select one): ☐ English ☐ Spanish ☐ Other_____

Preferred Pharmacy Name & Location:

Chose clinic because / referred to clinic by (Please check one box)
☐ Website ☐ Phone Book / Yellow Pages ☐ Newspaper ☐ Insurance Plan ☐ Family ☐ Physician Office ☐ Other

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 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 claim 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 claim chose in action or right against my insurers and/or employee health care plan.

Certain physicians (e.g. pathologists, laboratories and radiologists) may interpret your test results. These physicians may not be employees or agents of Creekside Medical Clinic and you may therefore receive a separate bill from these physicians for their services. You may also receive a separate charge on a subsequent day from the physicians for these services. The undersigned authorize these physicians to bill you and/or your 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.

Patient _____ Parent/Guardian (if applicable) _____ Date _____

Authorization for the use and Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, Creekside Medical Clinic may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

I,_____ , (print patient name or name of minor child) hereby authorize and request the use and disclosure of all the health information that pertains to me. I authorize and request Creekside Medical Clinic to make these disclosures of my health information. I authorize and request the following persons to receive these disclosures of my health information and elect not to provide statement of purpose for the use of the disclosure to the following persons (please print):

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer be protected. I understand that this authorization will automatically expire on December 31, 2020, but I may revoke this authorization at any time by signing the revocation section of my copy of this 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. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.

Signature of Patient
Or Parent of Minor Child

Date

Minor Consent Form

As the Parent/Guardian to_____ , a minor, I am authorizing the following.
Please initial in the provided blanks to those that you are authorizing.

1. ____ I authorize_____ , to be seen **without** a parent or guardian present.

2. ____ I authorize_____ , a minor, to be seen and treated at the Creekside Medical Clinic when accompanied **only** by the following adult, friend, child care provider, etc.

Name	Relationship
Name	Relationship

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

Parent or Guardian

Date

Only complete this section if you wish to revoke this authorization. HIPAA or MINOR CONSENT

Patient Name

Patient's Date of Birth

Parent of Guardian Signature

Today's Day