Rapid City Mental Health Prof. LLC
3939 Canyon Lake Drive Suite A
Rapid City, SD 57702
Phone 605-716-3555
Fax 605-413-1143

Jennifer Erdman CNP-PMHNP Amy Newstrom DNP-PMHNP, QMHP,LP-C Rachel Waddell CNP-PMHNP

PATIENT REGISTRATION FORM

PATIENT INFORMATION: **DATE:**_____

Last Name:_____ First Name:_____ Midde Name:_____
Address:_____ City:_____ State & Zip:_____
Birth Date: _____Phone:_____(please circle) home/cell/work
email Address:_____
(needed to access patient portal and receive appointment reminders)

PRIMARY INSURANCE INFORMATION:
Insurance Company:_____ ID#_____ Group# _____
Policy Holder:_____ DOB:_____ Relationship:_____
Address:_____ City, State, Zip: _____

SECONDARY INSURANCE INFORMATION:
Insurance Company:_____ ID#_____ Group# _____
Policy Holder:_____ DOB:_____ Relationship:_____
Address:_____ City, State, Zip: _____

REFERRING PHYSICIAN INFORMATION:
Name:_____ City & State:_____ Phone:_____

PRIMARY CARE PHYSICIAN:
Name:_____ City & State:_____ Phone:_____

EMERGENCY CONTACT:
Name:_____ Phone:_____ Relationship:_____

PHARMACY:
Name:_____ Address:_____ Zip Code:_____

FOR MINORS ONLY

Father Information:
Name:_____
Address:_____
City/State/Zip:_____
Phone:_____

Mother Information:
Name:_____
Address:_____
City/State/Zip:_____
Phone:_____

CONSENTS, AUTHORIZATIONS AND GUARANTEES

Patient's Name (Last, First, Initial) Date of Birth

By signing this consent, I certify that I have reviewed and agree to the terms and provisions of the RCMH Notice of Information Practices. The following is a summary of those terms and provisions. If I have any questions, I have received satisfactory answers before signing this Consent.

I understand that some things, by law, cannot be kept private. The exceptions to confidentiality are as follows, including but not limited to: If RCMH is ordered to testify in, or provide documents to, a Court of Law, they may have to give information regarding my case without my permission. If RCMH learns that harm has been done to a child or an elderly person, they may be required to inform the authorities. If RCMH learns that someone or something might be seriously harmed in the future, or that a patient intends to commit an act of violence, it may be RCMH responsibility to protect me, or others, by informing them and the authorities. If I am being treated under a Worker Compensation claim, and/or if there are indications of a need for other specialized treatment, necessary PHI may be released to an appropriate referral provider to facilitate this treatment.

Consent and Authorization for Treatment and Scheduling of Appointments

I hereby authorize RCMH and its professional staff to provide treatment to myself, or the person named above for whom I am legally responsible for medical and/or financial decisions, to include psychiatric assessments, medication management, and/or other mental health services. **I understand I am to notify RCMH of a request to cancel an appointment 24 hours prior to the time of the appointment to be canceled. If I fail to make such timely notification, RCMH may refuse to schedule future appointments.**

I explicitly authorize RCMH to use or disclose my protected health information to contact me to remind me of appointments. RCMH may call my contact phone number(s) and leave messages to remind me of the time and date of my next appointment at RCMH.

Explicit Consent and Authorization for Use and Disclosure of Protected Health Information (PHI)

In signing this form, I do hereby consent and authorize RCMH to the use and disclosure of my Protected Health Information by RCMH, its staff, and its business associates for the purpose of treatment, payment, and health care operations as detailed in its current Notice of Information Practices. I have reviewed the RCMH Notice of Information Practices prior to signing this consent/authorization form, and have received a copy if I so request. I understand the RCMH Notice of Information Practices may change at RCMH's discretion, as necessary.

I understand I may request that restrictions on how my protected health information is used and disclosed, by completing a RCMH Request to Restrict Use and Disclosure of PHI form. We have the right, however, to deny your request. You may also revoke this consent, in writing. Information on treatment and services provided on prior consents may still be used for purposes of treatment, payment, or health care operations. Please refer to the RCMH Notice of Information Practices for further information.

Patient or Legal Guardian Signature Date

Authorization of PHI Disclosure and Assignment of Health Plan Benefits

I explicitly authorize and request RCMH, as a holder of PHI and other information about myself, or the person named above for whom I am legally responsible for medical and/or financial decisions, to release to the Medicare, or any other health plan any information needed to determine benefits or pay claims on my behalf. This PHI may include psychiatric and/or psychotherapy notes, unless specifically prohibited by me. I request that payment of all health plan benefits to be made to on my behalf, directly to RCMH.

PLEASE NOTE: Should you refuse to allow release of records to insurance for the purpose of paying a claim, the fees for the services in question will become **YOUR RESPONSIBILITY**.

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Advanced Beneficiary Notice (ABN)

Please check which applies to you.

☐ **Opting out for Medicare**

Medicare Fee-for-Service (FFS) beneficiaries make informed decisions about items and services Medicare usually covers but may not cover in specific situations.

All services, therapies or charges will not be covered by Medicare at Rapid City Mental Health Professionals LLC as we are not contracted care providers. In order to offer you these services, we must make you aware that we will be charging you directly and that you as the patient will be responsible for payment for these services before they are administered. Since these services are not covered by insurance, we will not be able to file a claim.

☐ **No insurance policy – self pay**

Self-pay, non-private, Medicare/Medicaid insurance plans. You will be charged for the visit based on time spent. You are expected to pay prior to your visit. If you arrive without the ability to pay for your appointment you will be rescheduled and medications may not be refilled until you can arrange for payment for service.

☐ **Private Health Insurance**

For patients with private health insurance RCMH is contracted with Avera, Dakota Care, Health Partners, Sanford, and Wellmark/Blue Cross/Blue Shield. **After 5/1/23** (end of COVID emergency precautions and telemedicine) you may opt to have a phone appointment if your provider deems appropriate. You will be charged self-pay rates. You must pay at the time of the service and an insurance claim will not be filed.

Special circumstance insurance policies do allow forms of telehealth at RCMH past the date of 5/1/23. This has been prearranged and known to the patient and staff at RCMH via an eligibility check. If you wish to have our billers file your claim and it is discounted in any way due to telehealth care, you will be balance billed for the remainder of our usual fees.

This consent remains in effect for three years.

Patient or legal guardian_____

Date_____

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Stimulants (e.g., Adderall, Ritalin, Focalin, Vyvanse, Concerta, etc.) **Benzodiazepines** (e.g., Lorazepam, Xanax etc.) and **hypnotics** (e.g., Ambien, Lunesta, etc.) are controlled substances. These medications are carefully monitored by your provider and the state of SD. The medications will not be replaced if lost, stolen, damaged or misused (taking more than prescribed). It is your responsibility to keep these medications in a safe place and take them as directed by your provider.

Patients who are prescribed a controlled substance medication need to complete a follow up appointment every three months per state law. If you do not attend your scheduled 90-day appointment, you may not receive your refills.

A provider may discontinue a medication at any time if there is suspected misuse.

Patient _____

Legal guardian_____

Date_____

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Guarantee of Payment, Authorization or PHI Disclosure, and Assignment of Patient Due Balances

I understand, and hereby guarantee, that I will pay the patient portion of fees incurred on the day of the appointment and any past balances due. I hereby authorize RCMH to assign any balance due charges, for which I am responsible, to any of its business associates for the purposes of billing and collecting such charges. I further understand that I am responsible for any and all of RCMH's usual and customary charges not paid by my health plan, except those contractually discounted.

I understand that if I do not pay the balances due within 90 days of services, a 3% late charge will incur, and balances may be forwarded to collections. If I am unable to fulfill my agreement to pay for services rendered at RCMH, I may be unable to schedule further appointments at RCMH and may not receive medication refills.

I understand all these authorizations will remain effective for three years after I have stopped being an active patient of RCMH.

No Show Fee

To provide effective and efficient treatment to all our patients, cancellations must be made at least 24 hours prior to your scheduled appointment time. Rapid City Mental Health reserves the right to charge a No Show Fee as follows:

- $260.00 for new patient evaluations
- $100.00 for 30-minute follow-ups
- $85.00 for 15-minute follow-ups

Payment Policy for Self-Pay Patients

Payment in full is due at the time of service for self-pay patients. If payment is not made at the time of service, the appointment will need to be rescheduled.

Balance Policy

Patients with a balance exceeding $200.00 will not be seen until the balance is paid in full or a payment arrangement is set up.

Patient_____

Parent or legal guardian_____ Date_____

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Office Visits

New patient psychiatric evaluation - $380.00 for one hour

Follow up appointment - $140.00 for 20-29 minutes (includes appointment time and provider charting)

Follow up appointment - $200.00 for 30-40 minutes (includes appointment time and provider charting)

Follow up appointment - $255.00 for 40-54 minutes (includes appointment time and provider charting)

Therapy Rates

Psychotherapy with patient 30 minutes - $105.00

Psychotherapy with E/M 30 minutes - $105.00

Psychotherapy with patient 45 minutes - $145.00

Psychotherapy with patient 60 minutes - $185.00