RAPID CITY HEALTH PROFESSIONALS
Caring solutions for a healthier you!

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SCAN ME

PATIENT REGISTRATION FORM

PATIENT INFORMATION: **DATE:**_____

Last Name:_____ Street Address:_____

First Name:_____ City:_____

Middle Name:_____ State & Zip:_____

Birth Date:_____ Email:_____

Phone:_____ **(home / cell / work) – Needed for patient portal.**

PRIMARY INSURANCE INFORMATION:

Insurance Company:_____ ID#:_____ Group#:_____

Policy Holder:_____ DOB:_____ Relationship:_____

Address:_____ City/State/Zip:_____

REFERRING PHYSICIAN

Name:_____ City & State:_____ Phone:_____

PRIMARY CARE PHYSICIAN:

Name:_____ City & State:_____ Phone:_____

EMERGENCY CONTACT:

Name:_____ City & State:_____ Phone:_____

PHARMACY:

Name:_____ City & State:_____ Phone:_____

PLEASE REVIEW AND COMPLETE OTHER SIDE

CONSENTS, AUTHORIZATIONS, AND GUARANTEES

_____

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

By signing this consent, I certify that I have reviewed and agree to the terms and provisions of the Rapid City Health Professionals (RCHP) Notice of Information Practices. The following is a summary of those terms and provisions. If I have any questions, I certify that 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 RCHP 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 RCHP learns that harm has been done to a child or an elderly person, they may be required to inform the authorities. If RCHP learns that someone or something might be seriously harmed in the future, or that a patient intends to commit and act of violence, it may be RCHP 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 Protected Health Information (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 RCHP 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 physical assessments, medication management, and/or other medical health services. **I understand I am to notify RCHP 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 a timely notification, RCHP may refuse to schedule future appointments.**

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

Explicit Consent and Authorization for Use and Disclosure of Protected Health Information

In signing this form, I do hereby consent and authorize RCHP to the use and disclosure of my Protected Health Information by RCHP, 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 RCHP Notice of Information Practices prior to signing this consent/authorization form and have received a copy if I so request. I understand the RCHP Notice of Information Practices may change at RCHP's discretion, as necessary.

I understand that I may request that restrictions on how my protected health information is used and disclosed, by completing a RCHP 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 RCHP Notice of Information Practices for further information.

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Patient's Signature **Date of Birth**

Authorization of PHI Disclosure and Assignment of Health Plan Benefits

I explicitly authorize and request RCHP, as a holder of PHI and other information about myself, or the person named above for whom I am 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 be made on my behalf, directly to RCHP.

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.**