PATIENT REGISTRATION FORM **Chart # ___________________** **Date _____________**

Patients Name ____________________________________ Date of Birth ____________________ Age ______
Last First MI

Address ________________________________ City ________________________ State _______ Zip ______

Patients Social Security # _____________________ Marital Status S M W D

CONTACT INFORMATION

You have the right to request that our practice contact you about your health needs and related issues in a particular manner. Please be advised that this includes lab and test results, diagnosis, appointment and follow up care plans. Please indicate the acceptable means of contacting you.

☐ Home # __________________ Can we leave an answer on your machine Y N

☐ Cell # ____________________ Can we leave a message on your voicemail Y N

☐ Work # ___________________ Can we leave a message on your voicemail Y N

☐ By Mail ____

Who should we contact in the event of an emergency? ______________________________ Phone # _____________________

What is their relationship to you? ____

INSURANCE INFORMATION **Primary** ☐ Copy of Card Attached Initial __________

Primary Insurance Co _______________________ Policy # ________________ Group # ________________

Policy Holders Name _______________________ Date of Birth ____________ SS# ____________________

Policy Holders Employer ____________________ Employer Address ________________________________

Secondary ☐ Copy of Card Attached Initial __________

Secondary Insurance Co _____________________ Policy # ________________ Group # ________________

Policy Holders Name _______________________ Date of Birth ____________ SS# ____________________

Policy Holders Employer ____________________ Employer Address ________________________________

If patient is a minor please indicate who is financially responsible ____________________________________

For marketing purposes how did you come to choose BlackHills Ob/Gyn ______________________________

(Please turn over and fill out the reverse side)

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

1. I understand that as part of my health care, Black Hills Obstetrics and Gynecology originates, records, and maintains health information about me describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this health information may be used or disclosed by Black Hills Obstetrics and Gynecology for treatment, payment, and health care operations. For example, my health information serves as:

   - A basis for planning my care and treatment;
   - A means of communication among the many health professionals who contribute to my care;
   - A source of information for applying my diagnosis and surgical information to my bill;
   - A means by which a third-party payor can verify that services billed were actually provided; and
   - A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.

2. I acknowledge that I have been provided with Black Hills Obstetrics and Gynecology's Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice of Privacy prior to signing this consent. I understand that Black Hills Obstetrics and Gynecology reserves the right to change its Notice of Privacy Practices and prior to implementation will mail a copy of any revised notice to the address I have provided.

3. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and that Black Hills Obstetrics and Gynecology is not required to agree to the restrictions requested but if it does, it is bound by such restrictions.

4. I understand that I may revoke this consent in writing, except to the extent that Black Hills Obstetrics and Gynecology has already taken action in reliance thereon. This signed consent shall remain in force until the undersigned patient gives written notification, stating otherwise.

5. By signing this form, I consent to Black Hills Obstetrics and Gynecology's use and disclosure of my health information for treatment, payment, and health care operations.

6. I understand that this release of medical information may contain information regarding drug or alcohol abuse, mental health issues and/or HIV (AIDS) and STD (Sexually Transmitted Diseases)

   ☐ I do not have any restrictions to the use or disclosure of my health information.

   ☐ I request the following restrictions to the use or disclosure of my health information:

   ____

   _____________ Staff Initials ☐ Restrictions Accepted ☐ Restrictions Denied

7. I, the undersigned, hereby assign to the physician(s) associated with Black Hills Obstetrics & Gynecology LLP. all payments for medical services rendered to myself or my dependant.

Signature of Patient ____**Date**______________

Signature of Guardian or Legal Representative __________________________**Date**______________

Witness____**Date**_______________