Foothills Family
Health & Wellness

2920 W. Main St
Rapid City, SD 57702
Office: 605-719-7313
Fax: 605-719-7333

REGISTRATION FORM (PLEASE PRINT)				
Patient's Last Name:	First:	Middle:	Birth Date:	Age:
Marital Status (circle one) Single / Married / Div / Sep / Wid	Social Security Number:	Email:		Sex: ❑ M ❑ F
Street Address:	City:	State:	Zip Code:	Home Phone: ( )
PO Box:	Cell Phone:	Employer: Occupation:		Work Phone: ( )

IN CASE OF EMERGENCY		
Name of local friend/relative (not living at same address)	Relationship to patient:	Mobile phone: Home phone:

INSURANCE INFORMATION			
Person responsible for bill:	Birth Date:	Address (if different)	Home Phone:
Occupation:	Employer:	Employer Address:	Employer Phone:
Primary Insurance:	Subscriber Name and DOB:	ID #: Group #:	Patient relationship to subscriber:
Secondary Insurance:	Subscriber Name and DOB:	ID #: Group #:	Pt relationship to subscriber:
Is this visit due to an accident? (Circle one) Yes No	Date of Accident:	Type of accident: ❑ Auto: State _____ ❑ Other: _____	❑ Work Related _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Foothills Family Health & wellness or my insurance company to release any information required to process my claims.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgement. As provided in out Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy. By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all the purposes set out in our Notice. By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all your questions regarding the contents of our Notice have been answered.

Patient/Guardian signature: _____ *Date:* _____

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HIPAA RELEASE

RELEASE OF MEDICAL INFORMATION

Patient's FULL NAME (First, Middle, Last)	Date of Birth

BY SIGNING BELOW, I AUTHORIZE FOOTHILLS FAMILY HEALTH TO RELEASE MY MEDICAL/BILLING INFO TO:

Relationship to Patient	(circle Yes or No)		Name of Designated Person	Phone # of Designated Person
SPOUSE	YES	NO	_____	_____
CHILDREN	YES	NO	_____	_____
IN LAWS	YES	NO	_____	_____
CAREGIVERS	YES	NO	_____	_____
PARENTS	YES	NO	_____	_____
OTHERS	YES	NO	_____	_____

PATIENT SIGNATURE (or parent/guardian if minor)

SIGN: _____ **DATE**: _____

FINANCIAL POLICY

Thank you for choosing Foothills Family Health and Wellness to meet your medical needs. We are committed to providing you with the best treatment available. The following is a statement of our Financial Policy, which we request that you read and sign.

Co-pays and payment for services are due at the time services are rendered. For your convenience, we accept cash, checks and major credit cards.

Returned checks will be charged a twenty-five dollars ($25) handling fee. Balances over thirty (30) days will be subject to a handling charge of five dollars ($5.00). A minimum charge of twenty-five dollars ($25.00) will be made for missed appointments and appointments cancelled less than a twenty-four (24) hour advance notice.

If you have insurance, we will help you receive your maximum allowable benefits; however, you remain responsible for your co-pay and for payment if your claim is rejected. Sixty (60) days from the date of service is a reasonable amount of time for the insurance company to decide as to whether they will pay any of your claims. You will be responsible for the entire bill that has not been paid within the sixty (60) day period.

If you have any questions concerning your account, please feel free to ask our front office personnel.

I hereby confirm that I have read the above payment policy and agree to accept it.

PATIENT SIGNATURE *(or parent/guardian if minor):* _____

PRINT PATIENT NAME: _____ ***DATE***: _____