Michele Delzer, CNP

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PATIENT REGISTRATION FORM

Date: _____

PATIENT INFORMATION

- **Last Name:** _____
- **First Name:** _____
- **Middle Name:** _____
- **Birth Date:** _____
- **Street Address:** _____
- **City:** _____ **State/Zip:** _____
- **Email:** _____
- **Phone:** _____

(☐ Home ☐ Cell ☐ Work)

(Phone number required for patient portal access.)

PRIMARY INSURANCE INFORMATION

- **Insurance Company:** _____
- **ID #:** _____ **Group #:** _____
- **Policy Holder:** _____
- **Policy Holder DOB:** _____
- **Relationship to Patient:** _____
- **Address:** _____
- **City/State/Zip:** _____

REFERRING PHYSICIAN

- **Name:** _____
- **City/State:** _____
- **Phone:** _____

EMERGENCY CONTACT

- **Name:** _____
- **City/State:** _____
- **Phone:** _____

PRIMARY CARE PHYSICIAN

- **Name:** _____
- **City/State:** _____
- **Phone:** _____

PHARMACY

- **Name:** _____
- **City/State:** _____
- **Phone:** _____

CONSENTS, AUTHORIZATIONS, AND GUARANTEES

Printed Patient Name (Last, First, MI): _____
Date of Birth: _____

Notice of Information Practices

By signing below, I certify that I have reviewed and agree to the terms of the **Rapid City Health Professionals (RCHP) Notice of Information Practices**. I understand that:

- Certain information may not be kept confidential if required by law (e.g., court orders, reports of abuse, threats of violence, or workers' compensation cases).
- Protected Health Information (PHI) may be shared with referral providers if specialized treatment is needed.

Consent for Treatment and Appointments

- I authorize RCHP and its professional staff to provide treatment to myself (or the patient named above).
- Treatment may include physical assessments, medication management, and other medical services.
- I agree to notify RCHP at least **24 hours in advance** to cancel an appointment. Failure to do so may result in RCHP refusing to schedule future appointments.
- I consent to be contacted by RCHP (including voicemail messages) for appointment reminders.

Authorization for Use and Disclosure of PHI

- I authorize RCHP, its staff, and business associates to use and disclose my PHI for treatment, payment, and healthcare operations as outlined in the Notice of Information Practices.
- I may request restrictions on PHI use or revoke consent in writing; however, prior disclosures may still be used for treatment, payment, or operations.
- I acknowledge I have received, or may request, a copy of the Notice of Information Practices.

Patient Signature: _____ **Date of Birth:** _____

Authorization of PHI Disclosure & Assignment of Health Plan Benefits

- I authorize RCHP to release information, including PHI (which may include psychiatric or psychotherapy notes unless specifically restricted by me), to Medicare or other health plans for claim determination and payment.
- I request that payment of all health plan benefits be made directly to RCHP.
- I understand that **if I refuse to allow release of records to insurance for payment purposes, I will be fully responsible for all charges.**

Patient Signature: _____ **Date:** _____