DAKOTA PREMIER
MEDICAL CLINIC

Dakota Premier Medical Clinic New Patient Form

Demographic Information:

Date: _____

Patient Legal Name: _____ **Date of Birth**: _____
Last First MI

Patient Soc. Sec. #: _____ **Sex:** __Male __Female __ Decline

Address: _____
Street or BO Box City State Zip

Phone No. (_____) _____-_____ Email: _____

Marital Status: __Married __ Single __Divorced __Separated __Widowed __Other _____

Language: __English __Spanish __Other _____

Race: __White __American Indian or Alaskan Native __Asian __Hispanic __Black or African American
__Hawaiian or Pacific Islander __Other __Decline

Ethnicity: __Hispanic or Latino __Not Hispanic or Latino __Decline

Emergency Contact Information:

Emergency Contact Name: _____

Relationship to Patient: _____ **Phone No**. (_____) _____-_____

Employment:

__Employed __Unemployed __Retired __Disabled

Employed By: _____ **Work phone No.** (_____) _____-_____

Additional Information:

Preferred Pharmacy: _____

Pharmacy Address: _____

I authorize my provider to review my medication fill history.
__ Yes __No

How did you hear about us?
__ Social Media __ Website __ Referral __ Radio __ Other _____

I authorize Telehealth visits with my provider.
__ Yes __No

2006 Mt Rushmore Rd Suite 2 Rapid City, SD 57701
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Insurance Information:

Insurance Name: _____ **Policy Holder Name:** _____

Address: _____
Street or BO Box City State Zip

Policy Holder Date of Birth: _____ **Relationship to Patient:** _____ **Group Number:** _____

Policy Number: _____ **Payer ID Number**:_____ **Effective Date:**_____

Secondary Insurance Information:

Insurance Name: _____ **Policy Holder Name:** _____

Address: _____
Street or BO Box City State Zip

Policy Holder Date of Birth: _____ **Relationship to Patient:** _____**Group Number:** _____

Policy Number: _____ **Payer ID Number**:_____ **Effective Date:** _____

Responsible Party

Name: _____ **Date of Birth:** _____
Last First MI

Address: _____
Street or BO Box City State Zip

Relationship to Patient: _____ **Phone No.** (_____)_____-_____

Assignment of Benefit:
I hereby assign all medical benefits to which I am entitled to Dakota Premier Medical Clinic. I further authorize the assignee to obtain my plan provisions under ERISA and to act as an authorized representative on my behalf on insurance claims. This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including medical record copies, necessary to secure payment and to complete disability forms presented to me. In response to any reasonable request for cooperation, I agree to cooperate with Dakota Premier Medical Clinic in any attempts by Dakota Premier Medical Clinic to pursue such claim, chosen in action or right against my insurers and/or employee health care plan. Certain physicians (e.g. pathologists and radiologists) may interpret your test results. These physicians may not be employees or agents of Dakota Premier Medical Clinic and you may, therefore, receive a separate bill from these physicians for their services. A $40 plus tax service charge will be assessed against all non-sufficient funds/closed account checks. I have read and fully understand this agreement.

Patient's Name: _____ **Date:** _____

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HIPAA Privacy Authorization to Individuals

As required by the Health Insurance Portability and Accountability Act of 1996, Dakota Premier Medical Clinic may not use or disclose your health information to anyone without your authorization, except as provided in our Notice of Privacy Practice. Your signature on this form indicates that you are giving permission for the uses and disclosure described herein. You may revoke this authorization in writing at any time by signing and dating a revocation form and returning it to this office.

I, _____, authorize and request the following persons to receive these disclosures of my health information and elect not to provide a statement of purpose for the use of disclosure for the following persons:

Name: _____**Relationship:** _____ **Phone No.** (____) _____-_____

___All Health Information ___Progress Notes ___Lab Reports ___Image Reports___ Medications

___Other: _____

Name: _____**Relationship:** _____ **Phone No.** (____) _____-_____

___All Health Information ___Progress Notes ___Lab Reports ___Image Reports___ Medications

___Other: _____

Name: _____**Relationship:** _____ **Phone No.** (____) _____-_____

___All Health Information ___Progress Notes ___Lab Reports ___Image Reports___ Medications

___Other: _____

I understand that I am authorizing Dakota Premier Medical Clinic to make the above disclosure of my health information.
I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer be protected. I understand that this authorization will automatically expire one year from the date this form is signed, but that I may revoke this authorization at any time by signing the revocation section of the Use and Disclosure form and returning it to Dakota Premier Medical Clinic. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.

I have received a copy of Dakota Premier Medical Clinic's Privacy Notice.

Patient's Name:_____ **Date:**_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (Please provide specific details)

_____

_____

_____ _____

Employee Signature Date

This form does not constitute legal advice and covers only federal, not state, law.

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Consent for Medical Treatment

___I authorize to be seen and/or treated at Dakota Premier Medical Clinic facility.

I further understand this authorizes Dakota Premier Medical Clinic to provide medical and/or billing information to various laboratories, radiology, or other medical facilities for a test that may become necessary for treatment. I accept responsibility for all physician charges and laboratory fees.

Patient Signature: _____ **Date:** _____

Consent for Medical Treatment of a Minor

Children under the age of 14 must be accompanied by an adult for any appointment. As the Parent/Guardian of _____ a minor, I am authorizing the following:

____I authorize to be seen at Dakota Premier Medical Clinic without a parent or guardian present.

___I authorize a minor, to be seen and/or treated at Dakota Premier Medical Clinic facility when accompanied only by one of the following adults listed:

Name:_____**Relationship:** _____**Phone No. (_____)_____-_____**

Name:_____**Relationship:** _____**Phone No. (_____)_____-_____**

Name:_____**Relationship:** _____**Phone No. (_____)_____-_____**

I further understand this authorizes Dakota Premier Medical Clinic to provide medical and/or billing information to various laboratories, radiology, or other medical facilities for a test that may become necessary for treatment. I accept responsibility for all physician charges and laboratory fees. This authorization will remain in effect until revoked by me or the minor becomes 18.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ **Date:** _____

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Patient Portal Consent

Dakota Premier Medical Clinic, LLC offers secure viewing and communication as a service to patients and their personal representatives who wish to view parts of their records and communicate with our staff and providers. Secure messaging can be a valuable communications tool but has certain risks. To manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal works:
A secure web portal, such as HEALOW is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, and attachments. Secure messages and information can only be read by portal access managers due to (SSL) secure sockets layer technology. HEALOW uses information collected from users to provide services to authorized users to improve and personalize your visit experience, such as providing services to you and to communicate with you about information that you request. Through a user's interactions with the Services, HEALOW collects "Personal Information,", which is information that identifies an individual. Personal Information includes any information You have provided in connection with your use of the services. Personal Information is collected when you establish an account with HEALOW, or when you communicate with HEALOW about the site.

Protecting Your Private Health Information and Risks:
This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two additional factors: 1) the secure message must reach the correct email address, and 2) only the correct individual (or someone authorized by that individual) must be able to have access to the message. Only you can make sure these two factors are present. It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Types of Online Communication/Messaging:
Online communications should never be used for emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact your physician via telephone.

Dakota Premier Medical Clinic, LLC will never sell or distribute information provided in this patient portal. If you do not agree to let HEALOW have access to your personal information, please do not use these services.

By signing this form, I acknowledge and understand the terms and conditions of Patient Portal Access. I understand I may decline Patient Portal Access.

_____
Print Name: Patient's or Authorized Representative

☐ I Accept Patient Portal Access

☐ I Decline Patient Portal Access

_____
Patient's Signature or Authorized Representative

_____
Date

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AUTHORIZATION FOR RELEASE/DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____
Last First MI

Date of Birth: _____ Telephone Number: _____

Address:_____
Street or PO Box City State Zip

Purpose for this request: _____Continuing Care _____Personal Use _____Insurance _____Attorney _____Other_____

Information to be disclosed: _____Complete Health Record(s) _____Lab/Imaging Report(s) _____Progress Notes _____ Other_____

Date(s) of Service: _____

Request Records From:

Facility: _____

Address: _____
Street or PO Box City State Zip

Phone No. _____ Fax No. _____

Request Records To:

Facility: Dakota Premier Medical Clinic

Address: 2006 Mt. Rushmore Rd. Suite 2 Rapid City SD 57701
Street or PO Box City State Zip

Phone No. 605-416-9930 Fax No. 605-416-9931

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by submitting my request in writing. I understand that I do not have to sign this authorization. I understand that my treatment or payment for services will not be denied if I do not sign this form. Without my express revocation, this authorization will expire in 180 days from date of signature unless I direct a different expiration date here _____.

Signature of Patient or Representative:_____ Date: _____

Relationship to Patient (If Representative):_____