Rapid City OB/GYN
Dr. Rochelle Christensen, MD, FACOG

Patient Information:

Name: Last_______________________________________First______________________________MI_____

Address_____________________________________City_____________________State_____ Zip__________

Previous Names____ Date of Birth______/______/______

Social Security #______________________________ Marital Status_____________________________

Email ____ Pharmacy ______________________________

Employer _____________________________________

Ethnicity: Caucasian/White ☐
Native American ☐
Black/African American ☐
Asian ☐
Latin/Hispanic ☐

Contact Information:

Please check primary Contact:

Appointment Reminder method: ___Voice ____Email ____Text ____No Contact

☐ Home # _____________________________ Ok to leave message? Y N

☐ Cell # _______________________________ Ok to leave message? Y N

☐ Work # ______________________________ Ok to leave message? Y N

Emergency Contact ____ Phone #______________________

Relationship to patient _________________________ OK to discuss Medical/Financial Information? Y N

Insurance Information:

Primary Insurance ____________________________ Policy #: ____________________ Group #: __________

Policy Holder________________________________ Date of Birth: ________________ SS# _______________

Relationship to Patient; _______________________

Secondary Insurance____________________________ Policy #: _________________ Group #: ___________

Policy Holder________________________________ Date of Birth: ________________ SS# _______________

Relationship to Patient; _______________________

Guarantor of Payment (Complete this section if patient is a minor)

Name Last____________________________________First______________________________MI________

Address__________________________________City________________________State:_______Zip:______

Date of Birth ______/______/______Social Security # __________________________Marital Status: ________

Home Phone: __________________________ Cell Phone: __________________________

Acceptance of Financial Responsibility and Assignment of Benefits: I hereby authorize payment of benefits on my behalf under my insurance plan(s) and/or government-sponsored plan(s) directly to Rapid City OBGYN. I understand that if the providers of RC OBGYN are not participating providers with my insurance that I am responsible for amounts determined ineligible due to their "maximum allowable", "usual, customary and reasonable" or other payment policies. I agree to pay any co-pays, deductibles or co-insurances that are my responsibilities under my insurance plan(s). I understand I will be billed and held responsible for my account regardless of the status of any insurance claims.

Signed____Date____________________________

** **If you do not have insurance coverage**: I understand that I am responsible for payment at time of service. I am required to pay for at least half of the office visit and additional services on the day of the appointment. A payment plan must be set up for the remaining balance. If you choose and are able to pay you services in full, you will receive a 20% discount. ________ Initials

Consent of Treatment: I hereby consent to such medical treatment, including evaluation, diagnosis, treatment of care as ordered by my provider for myself or for whom I am the parent or authorized representative. I acknowledge no guarantees or promises have been made to me concerning the results of any procedure or treatment I receive.

Signed____Date____________________________

Authorization for Use and Disclosure of Protected Health Information (PHI): Our Notice of Privacy Practices outlines our obligations to you under federal privacy law. Your signature authorizes our use of your PHI to carryout treatment, payment and health care operation activities under state laws. The phone number (s) and address you provide us will be used to contact you for appointment reminders, medical follow-up, questions regarding account information, billing and insurance claims, mailing account statements and other contacts unless you tell us otherwise. **In addition, we ask you to let us know to whom you will allow access to your medical records, account and/or billing information.** We may ask you to complete an authorization for release of medical information if there are any questions or concerns.

BY SIGNING BELOW I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND HAVE RECEIVED A COPY OF RAPID CITY OBGYN NOTICE OF PRIVACY PRACTICES. (Located at the front desk)

Signed____Date__________________________________