Yankton Medical Clinic®, P.C.
Registration Form

Medical Record # _____

Form Must be Completed in its Entirety

Last Name	First Name	MI	Birthdate	Sex M / F	Maiden Name

Street Address / Mailing Address	City	State	Zip

Home Phone	Work Phone	Cell Phone	Social Security #
( )	( )	( )	

Email Address	Employer

Marital Status Mar. Wid. Sing. Div. Sep.	Spouse Name	Spouse Date of Birth
☐ ☐ ☐ ☐ ☐		

In Case of Emergency – Notify	Relationship	Telephone #	Address City State ZIP

Have you or any member of your immediate family been examined here before? Yes ☐ No ☐	If Yes, give name	Have you been in the Clinic under a different name? Yes ☐ No ☐	If Yes, give name

Primary Language (select one)

☐ English ☐ Spanish ☐ Other – Please List _____

Ethnicity	**Race**		
☐ Hispanic or Latino	☐ White	☐ Black or African American	☐ Asian
☐ NOT Hispanic or Latino	☐ Other _____	☐ American Indian	☐ Hispanic

Responsible Party for Household (If Different than Above)

Last Name	First Name	MI	Social Security #	Relationship to Patient

Telephone Number	Birthdate	Mailing Address	City	State	ZIP
( )					

Occupation	Employer	Address	Phone

INSURANCE INFORMATION

Primary Insurance_____ ID# _____ Group# _____

Policyholder name and birth date: _____

Relationship to patient: _____

Employer: _____ Effective Date:_____

Secondary Insurance _____ ID# _____ Group#_____

Policyholder name and birth date: _____

Relationship to patient: _____

Employer: _____ Effective Date:_____

Tertiary Insurance _____ ID# _____ Group#_____

Policyholder name and birth date: _____

Relationship to patient: _____

Employer: _____ Effective Date:_____

(PLEASE PRESENT ALL INSURANCE CARDS AND PHOTO ID TO RECEPTIONIST)

(**over**)

INSURANCE INFORMATION

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to my physician. I authorize my physician to release any information required to process my claim.

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGMENT

We are required by law to protect the privacy of your health care information, offer a copy of our Notice of Privacy Practices, and to follow the guidelines described in that notice. Your signature acknowledges you have been offered this notice. If you wish to receive a copy of your health care information you may do so by contacting our Medical Records Department or our Security Officer. Occasionally we may send you information about products or services that we believe may be beneficial to you. You may contact our Security Officer to request that these materials not be sent to you.

FINANCIAL POLICY

Our office is committed to providing quality and cost-effective healthcare to our patients. In today's insurance environment it is essential that you understand which services and procedures are covered by your insurance plan and obtain any necessary authorizations or referrals prior to your appointment with us. It is your responsibility to understand the limits and restrictions affecting coverage for services provided by our speciality. If your insurance company requires you to use a specific lab, it is your responsibility to notify us of that. Insurances reimbursement is a contract between you and your insurance company. As a courtesy to you we will file all primary and secondary claims for you. We will require a current copy of your insurance card in order to do this and will need to be informed of any change in insurance status. You will be responsible for all co-pays, deductibles, and co-insurance amounts not covered by a secondary insurance policy along with the entire amount of any non-covered service. We appreciate payment for services at the time they are rendered. For your convenience, we accept cash, personal checks, Visa, and MasterCard. I agree that I am financially responsible for all services provided and should it be necessary to refer the account to collections I will be responsible for all collection fees, collection costs, attorney fees and court costs involved with my account. I understand that interest of 1% per month compounded annually will be added on all unpaid balances over 90 days. I understand I am responsible for my spouse/dependent charges.

X SIGNATURE: _____ **DATE**: _____

PREVENTATIVE CARE

Your health insurance plan may not provide coverage for preventive services. It is important that you contact your insurance provider to determine if your plan offers benefits for this service and what their scheduling guidelines are for it. We use industry standard codes and guidelines to submit claims to the insurance companies based on the scheduled encounter and documentation in the patient's medical record. Current laws regarding fraud and abuse with billing procedures prohibit us from changing the procedure codes and /or diagnosis codes in order to get the claim paid by the insurance company.

To protect the healthcare team who may accidentally be exposed to my blood or body fluids, I consent to have my blood tested for transmissible disease (such as hepatitis virus, HIV (AIDS), others). If this testing is necessary it will be done at no charge. Your physician will inform you if this should become necessary.

X SIGNATURE: _____ **DATE**: _____

AUTHORIZATION TO SHARE HEALTH CARE INFORMATION (OPTIONAL)

You may share the following health care information with:

Name: _____ Relationship: _____

Please check all that apply:

☐ All health care information in my medical record. ☐ Insurance and billing information

☐ Health care information in my medical record relating to the following treatment:_____

☐ Other (appointments, test results, etc.) _____

This authorization ends:

☐ In 1 year from the date signed. ☐ Upon written revocation.

X SIGNATURE: _____ **DATE**: _____

YANKTON MEDICAL CLINIC®, P.C.

So much care, so close to home.®