MEDICAL RECORD # ______________________ DATE ______________

Advanced Dermatology of the Black Hills, P.C. **REGISTRATION FORM**

PATIENT INFORMATION

REFERRING PHYSICIAN'S NAME ______________________

NAME LAST	FIRST	M.I.	EMAIL ADDRESS

MAILING ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE
				( )

SEX	DATE OF BIRTH	MARITAL STATUS	CELL PHONE
M F	MO. - DAY - YR.	☐ SINGLE ☐ WIDOWED ☐ MARRIED ☐ DIVORCED	( )

EMPLOYER'S NAME AND ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE
				( )

RESPONSIBLE PARTY

☐ **IF SAME AS ABOVE CHECK HERE**

NAME LAST	FIRST	M.I.	DATE OF BIRTH
			MO. - DAY - YR.

MAILING ADDRESS	CITY	STATE	ZIP CODE	RELATIONSHIP

RESPONSIBLE PARTY'S EMPLOYER NAME AND ADDRESS	CITY	STATE	ZIP CODE

RESP. PARTY HOME PH.#	RESP. PARTY WORK PH. #
( )	( )

ASSIGNMENT OF BENEFITS - AUTHORIZATION TO RELEASE INFORMATION - FINANCIAL RESPONSIBILITY

WITH MY CONSENT **ADVANCED DERMATOLOGY OF THE BLACK HILLS, P.C.** MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) ABOUT ME TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS (TPO).

I HAVE THE RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS CONSENT. **ADVANCED DERMATOLOGY OF THE BLACK HILLS, P.C.** RESERVES THE RIGHT TO REVISE ITS NOTICE OF PRIVACY PRACTICES AT ANY TIME. A REVISED NOTICE OF PRIVACY PRACTICES MAY BE OBTAINED BY FORWARDING A WRITTEN REQUEST TO **ADVANCED DERMATOLOGY OF THE BLACK HILLS, P.C.** PRIVACY OFFICER, 710 ST ANNE STREET, RAPID CITY, SD 57701

ADVANCED DERMATOLOGY OF THE BLACK HILLS, P.C. MAY CALL ☐ HOME ☐ WORK ☐ CELL

LEAVE VOICEMAIL OR MESSAGE ON ANSWERING MACHINE ☐ YES ☐ NO

MAY DISCUSS HEALTH INFORMATION WITH FAMILY ☐ YES ☐ NO

I HEREBY ASSIGN ALL MEDICAL/SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH PLAN TO: **ADVANCED DERMATOLOGY OF THE BLACK HILLS, P.C.**

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 NECESSARY TO SECURE PAYMENT AND TO COMPLETE DISABILITY FORMS PRESENTED TO ME.

SIGNED ______________________ DATE ____________