MITCHELL CLINIC
818 W HAVENS MITCHELL, SD 57301 PHONE (605)996-7526 FAX (605)996-1808
www.mitchellclinic.ltd

PATIENT'S FIRST NAME	PREFERRED NAME	MI	LAST	SEX

RACE
☐AMERICAN INDIAN/NATIVE AMERICAN
☐CAUCASIAN/WHITE
☐ALASKA NATIVE
☐BLACK/AFRICAN AMERICAN
☐OTHER________

MAILING ADDRESS WITH APT # IF APPLICABLE   CITY, STATE, ZIP

*PREFERRED PHONE*__________ ☐ HOME ☐CELL ☐WORK

*ALTERNATE PHONE*__________ ☐HOME ☐CELL ☐WORK

DATE OF BIRTH   SOCIAL SECURITY #

There may be times our office needs to contact you to discuss your care.
I give permission to contact me by phone at ☐HOME ☐CELL ☐WORK
I give permission for Mitchell Clinic, Ltd. personnel to leave messages regarding appointments, treatment, etc., and to release verbal information as described above. Messages may be left on my phone at ☐HOME ☐CELL ☐WORK

MARITAL STATUS M D S W

PATIENT EMPLOYER

SPOUSE__________DOB________

PREFERRED PHONE__________ ☐ HOME ☐CELL ☐WORK

EMERGENCY CONTACT NAME AND PHONE

IF PATIENT IS A MINOR, PLEASE COMPLETE

MOTHER'S NAME__________DOB________ADDRESS__________

FATHER'S NAME__________DOB________ADDRESS__________

PERSON/GUARANTOR RESPONSIBLE FOR PAYMENT OF SERVICES(IF DIFFERENT FROM PATIENT)

Guarantor: Is your address the same as the Patient/Minor's address? ☐YES ☐NO (if no, provide information below)

NAME OF GUARANTOR__________PHONE__________

MAILING ADDRESS__________(Apt)________City__________State________Zip________

All patients are expected to pay their insurance co-pay to Mitchell Clinic, Ltd. upon registration for every visit. A co-pay is an agreement between the patient and their insurance company and between the insurance company and Mitchell Clinic, Ltd.

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE NAME__________	INSURANCE NAME__________
CLAIMS ADDRESS__________	CLAIMS ADDRESS__________
SUBSCRIBER__________	SUBSCRIBER__________
RELATION TO PATIENT________ ☐FAMILY COVERAGE	RELATION TO PATIENT________ ☐FAMILY COVERAGE
ID__________GROUP________	ID__________GROUP________
EFFECTIVE DATE__________	EFFECTIVE DATE__________

AUTHORIZATION FOR TREATMENT: Realizing that I require medical care, I do hereby voluntarily consent to such medical care encompassing such diagnostic procedures and medical treatment by my provider, his\her assistants, or designees including consulting providers, employees and students in educational programs affiliated with Mitchell Clinic, Ltd., as is necessary in the judgment of my provider. I consent to testing for HIV(AIDS) and/or Hepatitis should a healthcare worker have accidental exposure to my blood or other body substances.

RELEASE OF INFORMATION: I hereby authorize Mitchell Clinic, Ltd. to release diagnostic and procedural information for the completion of insurance claim forms. I hereby authorize the release of clinical information to third party payers and\or their reviewing contractors to comply with preadmission review and continued stays requirements. I authorize the release of clinical information to referring physicians and facilities for the purpose of continued health care.

ASSIGNMENT OF BENEFITS: Authorization is hereby granted for the direct payment to Mitchell Clinic, Ltd. for all benefits payable to me. I understand I am financially responsible for all charges regardless of insurance coverage.

PATIENT SIGNATURE__________ DATE__________

PATIENT REPRESENTATIVE__________ RELATIONSHIP TO PATIENT__________