Mitchell Clinic, Ltd.

"Professional Care by Caring Professionals"

P.H. Rasmussen, M.D.
D.M. Holum, M.D.
M.D. Gerlach M.D.
Gina Hawkins, PA-C
Sarah Goral, PA-C

Family Medicine Specialists

Hello!

Thank you for your interest in Mitchell Clinic. Our office has 5 different providers to choose from. We have 3 family medicine doctors – Dr. Rasmussen, Dr. Holum, and Dr. Gerlach. We also have 2 P.A.'s (Physician Assistants) – Gina Hawkins and Sarah Goral. Our office has plenty to offer to help meet your medical needs. We have a lab department where we are able to do most lab tests. We also have our own radiology department for your x-ray needs. We have the ability to do several different procedures at our office such as colonoscopies, Upper Endoscopies, lesion removals, cardiac stress tests, and joint injections. Attached to this letter, you will find a registration form; an authorization to discuss treatment about your healthcare and/or billing needs; a new patient questionnaire; a history questionnaire; a medical authorization form to have your prior healthcare records sent to us; and a billing guideline including the insurances that we participate with. We look forward to seeing you as a patient!

Thank you,

Mitchell Clinic, Ltd.

818 West Havens
Mitchell, SD 57301
Phone: 605-996-7526
Fax: 605-996-1808

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_____

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AUTHORIZATION TO DISCUSS TREATMENT

There may be occasions when you want to give another person the ability to discuss your care at Mitchell Clinic, Ltd. (billing, treatment, appointments, prescriptions,etc.). Examples include spouse, parent (if you are over 18), another family member, coach, nursing home staff, care provider, etc. This authorization will allow discussion only. It does not authorize the release of medical records. I give my permission for Mitchell Clinic, Ltd. personnel to share information verbally regarding my treatment at Mitchell Clinic, Ltd. with the following person(s):

NAME:_____ RELATIONSHIP_____PHONE_____

NAME:_____ RELATIONSHIP_____PHONE_____

NAME:_____ RELATIONSHIP_____PHONE_____

The above authorization will expire on_____.

Do you have a durable power of attorney for healthcare? ☐YES ☐NO
IF YES, PLEASE PROVIDE A COPY TO THE OFFICE FOR YOUR MEDICAL RECORD

I acknowledge that the Notice of Privacy Practices is available upon request. Mitchell Clinic, Ltd. 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 Mitchell Clinic, Ltd., 818 W Havens, Mitchell, SD 57301.

PATIENT SIGNATURE_____ _

PATIENT REPRESENTATIVE_____

RELATIONSHIP TO PATIENT_____

DATE_____

New Patient Information:

1. Where have you been receiving medical care?

2. Why are you seeking to change?

3. Which doctor would you like to see?

4. What is your current health need?

5. How did you hear about us? (please circle one)

   - Family/Friend
   - Website
   - Facebook page
   - Physician referral
   - Newspaper
   - Other _____

PATIENT HISTORY QUESTIONNAIRE MITCHELL CLINIC, LTD.

Name	age	sex M F	birth date

1. What type of work do you do?	marital status (please circle) married single divorced widowed

2. What other types of work have you done?

3. Have you ever lived overseas? If so where?

4. Tobacco usage	yes	no	amount per day	# of years	Beverage consumption	yes	no	amount per day
Cigarettes					Alcoholic beverages			
Cigar					Coffee or tea			
Pipe / chew					Caffeine containing soda pop			
If not, have you ever smoked?					When did you stop smoking?			

What drugs or medicines do you take regularly? (These include medicines that were prescribed by a physician and also medicines or vitamins that you can buy yourself without a prescription)	Name of prescription medicine	Amount per day	Name of nonprescription medicine or drug	Amount per day
	1.		1.	
	2.		2.	
	3.		3.	
	4.		4.	
	5.		5.	
	6.		6.	
	7.		7.	

What foods or medicines are you allergic to?	1.	2.	3.
	4.	5.	6.

	Type	Hospital	Date
What surgeries have you had?	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
	Reason for hospitalization	Hospital	Date
What other hospital-izations have you had?	1.		
	2.		
	3.		
	4.		
	5.		
	6.		

FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH (list any medical problems)	IF DEAD, CAUSE OF DEATH (be specific)	Age at Death
FATHER				
MOTHER				
B S				
B S				
B S				
B S				
B S				
B S				

IS THERE A HISTORY OF ANY OF THE FOLLOWING IN YOUR FAMILY?

	YES	NO		YES	NO		YES	NO
TB			HEART DISEASE			MENTAL ILLNESS		
DIABETES			SKIN DISEASE			CANCER		
KIDNEY DISEASE			BLOOD DISEASE			FREE BLEEDING IN FAMILY		

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD:

	YES	NO		YES	NO		YES	NO
A STROKE			HIGH BLOOD PRESSURE			ANEMIA		
MIGRAINE HEADACHES			STOMACH OR DUODENAL ULCER			GOUT		
A SEIZURE			GALLSTONES			DIABETES		
THYROID PROBLEMS			YELLOW JAUNDICE			ARTHRITIS		
ASTHMA			PANCREATITIS			BLEEDING DISORDER		
EMPHYSEMA			KIDNEY STONE			CANCER (state type)		
TUBERCULOSIS			KIDNEY INFECTION					
HEART ATTACK			BLADDER INFECTION			MENTAL ILLNESS		
HEART FAILURE			PROSTATE PROBLEM					
HEART MURMUR			VENEREAL DISEASE (state type)					
RHEUMATIC FEVER								

Please list other problems not specified above.

Please list broken bones or injuries which required a physicians care (give dates)		**TODAY'S DATE**

THIS SECTION FOR WOMEN ONLY

Age at onset of menstruation	When was your last normal period?	Number of pregnancies
Number of living children	Number of stillborn or miscarriages	

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AUTHORIZATION

FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

Date needed by:_____ ☐ Pick up ☐Mail ☐Fax

Today's Date:_____
(THIS FORM WILL EXPIRE ONE YEAR FROM THE DATE ABOVE)

Name of Patient (please print full name):_____

DOB:_____ Phone:_____

Patient's complete address:_____

Name of person requesting records transfer(if other than patient):_____

Relationship to patient:_____

Phone number where you can be reached for questions:_____

The records will be *SENT FROM:*

Name: _____ Facility: _____

Address: _____ Phone: _____

City, State, Zip: _____ Fax: _____

The records will be *SENT TO:*

Name: _____ Facility: _____

Address: _____ Phone: _____

City, State, Zip: _____ Fax: _____

What information do you want sent? Please check the appropriate boxes.

☐ Dictation/Notes ☐ Operative Reports ☐Radiology/Reports ☐Labs
☐ Medication Lists ☐Complete Record ☐ Consults from Dr_____
☐ Other_____ ☐ Specific Timeframe From:_____To:_____

Purpose of Disclosure (please be specific):

☐ Specialist referral ☐Consult/Second Opinion ☐Transfer of Care ☐Insurance
☐Legal ☐Other (Specify):_____

I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected my federal confidentiality rule.
I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and I understand that the revocation will not apply to information already released bas on this authorization.
I understand that authorizing this disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Signature of patient:_____ Date:_____

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Billing Guidelines

Our office requires a down payment of $50.00 for all new patients, which is due at the first appointment. This amount is used to establish credit with us. It is not a separate fee. It is applied towards any deductible, coinsurance, or copay amounts that you are responsible for after your insurance processes your claim. If there is a credit after your insurance processes your claim, that credit would be refunded back to you. We do allow monthly payments if payment in full is not possible. Since we are a private practice, we are able to offer in network benefits for both Avera (including Dakotacare) and Sanford. We also participate with Blue Cross Blue Shield, Cigna, Health Partners, Medica, United Healthcare; and we use the networks of Labor Care and America's PPO.

If your insurance is not listed above, we would be considered out of network, which may lead to more out of pocket costs. If you have questions regarding your coverage, please contact your insurance company as we do not verify benefits or coverage.

For those with Medicare: Our office DOES accept Medicare assignment.

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