Dakota Women's Clinic

Michael Krause, DO, FACOG, OB/GYN • Michele Peitz, PA-C

625 North Foster, Suite 108 • Mitchell, SD 57301 • 605.990.1995 • Fax 605.990.1839

PATIENT NAME (Please print full LEGAL name)
First Name: ____________________ MI: ________
Last Name: ______________________________
Prefer to be called: ________________________
Date of Birth: ____/____/______ Age: ______
Social Security Number: _____-_____-______
Address: ________________________________
City: _______________State:______Zip:________
Home Phone: __________Cell Phone: _________
Preferred Method of Contact: [ ] e-mail [ ] mail
[ ] cell phone [ ] home phone [ ] work phone

Who is responsible for payment
(if other than patient)?:

____
Address: ___________________________________
City:__________________State:_______Zip:____
Home phone:_________________________________
Cell phone: _________________________________
Employer: __________________________________
Relationship to patient: ______________________

Preferred Language: ________________ [ ] Decline
Race: [ ] American Indian [ ] Asian [ ] Black
[ ] White [ ] Native Hawaiian [ ] Decline
Ethnicity: [ ] Decline [ ] Hispanic Origin
[ ] Non-Hispanic Origin

Employed: [ ] Yes [ ] No
Employer's Name: ___________________________
Address: ___________________________________
City: ________________State:_______Zip:______
Work Phone:_________________________________
Occupation: ________________________________
Student: [ ] Yes [ ] No

Patient Status:
[ ] Single [ ] Married [ ] Child [ ] Other
If married, name of spouse: __________________

Name of person to contact in emergency:
____
Relationship: ________________________________
Home Phone: _________________________________
Work Phone:__________________________________

FOR ALL PATIENTS:
Primary Insurance information:
Insurance Company Name:____________________
Address: ___________________________________
Policyholder Name: __________________________
Policyholder DOB: ___________________________
Policyholder Employer: _______________________
Relationship to policyholder: __________________
ID#____________________Group#:_____________

Secondary Insurance Information:
Insurance Company Name:____________________
Address: ___________________________________
Policyholder Name: __________________________
Policyholder DOB: ___________________________
Policyholder Employer: _______________________
Relationship to policyholder: __________________
ID#____________________Group#:_____________

If you have Medicaid, PCP: ___________________

AUTHORIZATION TO DISCUSS TREATMENT

There may be occasions when you want to give another person the ability to discuss your care at Dakota Women's Clinic (billing, treatment, appointments, prescriptions, etc.). Examples include spouse, parent (if you are over 18), another family member, adult child, 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 Dakota Women's Clinic personnel to share information verbally regarding my treatment at Dakota Women's Clinic with the following person(s):

NAME: ______________________ RELATIONSHIP: ______________________
NAME: ______________________ RELATIONSHIP: ______________________

There may be occasions when Dakota Women's Clinic needs to contact you to discuss your care.
I give permission to contact me by phone at: [ ] Home [ ] Cell [ ] Work

I give permission for Dakota Women's Clinic 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

AUTHORIZATION TO PAY DAKOTA WOMEN'S CLINIC, MICHAEL R. KRAUSE, DO PC

I authorize payment directly to Dakota Women's Clinic, Michael R. Krause, DO, PC of benefits payable under this policy. I understand that I will be financially responsible to Dakota Women's Clinic, Michael R. Krause, DO, PC for any charges not covered by this policy. It is the objective of this office to provide our patients with the best available care at a reasonable cost. In an effort to eliminate the expense of billing and collection, we ask that you pay for these services as rendered. A service charge of 1.5% will be added to accounts over 90 days past due. If you have insurance, please understand that this is an agreement between you and your insurance company to pay certain amounts for medical care. Our bill for service is an agreement between you and us. If unusual circumstances should make it impossible to meet our credit terms, please call to discuss the matter with our billing manager. This will avoid misunderstanding and enable you to keep your account in good standing.

E-PRESCRIBING AUTHORIZATION

#1 [ ] I agree that Dakota Women's Clinic may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

#2 [ ] I do not consent to Dakota Women's Clinic receiving my prescription medication history.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (please check only one box)

#1 [ ] The undersigned hereby acknowledges that he/she was offered the Dakota women's Clinic Summary of Notice of Privacy Policies and declined a copy.

OR

#2 [ ] The undersigned hereby acknowledges receipt of the Dakota Women's Clinic Summary Notice of Privacy Practices.

E-Mail Address: ______________________________

AUTHORIZATION FOR ELECTRONIC COMMUNICATION

#1 [ ] I agree and consent to receive electronic communication sent to me by Dakota Women's Clinic.

OR

#2 [ ] I do not consent to electronic communication to and from Dakota Women's Clinic

SIGNATURE: ______________________________ DATE: ______________