Magnolia Family Practice

Office use only: _____ **Date:** _____

Last Name: II/III/IV/Jr/Sr	**First Name:**	**MI:**
Social Security# - -	**Date of Birth:** / /	**Sex:** M or F
Address:	**City:**	**State:** **Zip:**

Home Phone ( ) -	**Cell Phone**: ( ) -	**Work Phone**: ( ) -

Contact Preference: □ Home □ Cell □ Work □ Other ( ) -

Marital Status:	**Language:**	**Race:**	**Ethnicity:**
□ Single □ Married □ Divorced □ Widowed □ Separated	□ English □ Spanish □ Other _____	□ African American □ Asian □ Hispanic □ Other Pacific Islander □ White □ Other Race □ Do not wish to report	□ Hispanic or Latino □ Not Hispanic or Latino □ Do not wish to report

Employment:	**Employer:**	**Student Status:**
□ Employed □ Self Employed □ Unemployed □ Retired		□ Not a student □ Full Time student □ Part Time student
Emergency Contact:	**Emergency Contact Phone:** ( ) -	**Relationship:**

Patient Portal/Email Consent:

□ **YES,** I hereby authorize Magnolia Family Practice, LLC to use the e-mail address I have provided as a means to communicate test results and other information to me through the patient portal.

E-mail: _____

□ **NO,** I do not wish to communicate through the patient portal and would prefer to be reached by phone for any communications.

- □ **Do not have email address**
- □ **Do not wish to disclose email address**

_____

↑ Signature of patient or legal guardian ↑

Authorization For Prescription History:

I consent to allow the physicians of Magnolia Family Practice, LLC and appropriate staff to view my prescription history from external sources.

□ **Yes**, I give permission for the physicians of Magnolia Family Practice, LLC and the appropriate staff to have access to any of my prescription history from external sources.

□ **No**, I do not wish to give permission for anyone to have access to any of my prior prescription history from any external sources.

_____ _____/_____/_____

↑ Signature of patient or legal guardian ↑ Date

Name of Pharmacy that you prefer:_____

HIPAA Information

Authorization To Disclose Health Information:

****We cannot release any information (I.e. prescriptions, appointment or financial info), if the person(s), such as a family member or friend, is not listed as one of your authorized HIPAA contacts.**** I hereby authorize the use and disclosure of my identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the person authorized to receive the information is not from a health plan or another healthcare provider, the released information may no longer be protected by federal privacy regulations.

Name:_____ Relationship_____

Phone: ( ) -

Name:_____ Relationship_____

Phone: ( ) -

Name:_____ Relationship_____

Phone: ( ) -

□ **YES,** I give permission for the above person(s) to have access to my medical information.

□ **NO,** I do not wish to give permission for anyone to have access to any of my medical information.

_____ _____/_____/_____

↑ Signature of patient or legal guardian ↑ **Date**

Authorization For Treatment:

I consent to treatment by the providers of Magnolia Family Practice, LLC and to the appropriate test(s) for the presence of infection and/or other medical conditions if deemed necessary and I authorize the withdrawal of blood or other body fluids for this purpose.

_____ _____/_____/_____

↑ Signature of patient or legal guardian ↑ **Date**

Advance Directives

Do you have any Advance Directive Forms that we should have in your chart? **If so, make sure to provide us with a copy.**

□ DNR (Do Not Resuscitate)
□ POA (Power of Attorney)
□ Living Will
□ Custody
□ Other _____
□ Not Applicable

Health Insurance Information

****If correct health insurance information is not provided, you will be considered Self Pay and payment will be due at time of service.****

Complete this section if responsible party is not the patient :		
Financially Responsible Party		
Responsible Party's Name:	**Address if different from patient:**	
Phone: ( ) -	**Social Security#** - -	**Date of Birth:** / /

Complete the following Insurance Information:	
Primary Insurance Information	
Insurance Name:	**Policy Number/Member ID:** _____
	Group Number: _____
Policy Holder's Name:	**Policy Holder's SSN:** - -
Policy Holder's Date of Birth: / /	**Relationship to patient:**
Secondary Insurance Information	
Insurance Name:	**Policy Number/Member ID:** _____
	Group Number: _____
Policy Holder's Name:	**Policy Holder's SSN:** - -
Policy Holder's Date of Birth: / /	**Relationship to patient:**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Magnolia Family Practice, LLC. I understand that I am financially responsible for any balance. I also authorize Magnolia Family Practice, LLC or my insurance company to release any information required to process my claims.

_____ _____/_____/_____

↑ Signature of patient or legal guardian ↑ **Date**

Patient Financial Policy

It is the goal of Magnolia Family Practice, LLC to provide the best care on your behalf. It is also our desire to assist you in the financial arrangements related to this care. Therefore, it is important for you to fully understand our insurance and collections policies, prior to services being rendered. Please read the following information carefully and feel free to ask any questions you may have. We ask that you initial this statement when you have read and understand each point covered.

Upon registration, you will be asked for the following:

- Picture I.D. (if the patient is a minor, a picture I.D. will be required of a parent/legal guardian).
- Insurance card(s) for verification of insurance coverage and benefits
- Completed patient information forms. These are also required to be updated yearly.
- Co-payments
- Delinquent/prior balance amounts

Payment is due at time of service. Please be prepared with your copayment, deductible, or co-insurance at each visit. This includes scheduled appointments, urgent visits, labs and nurse visits.

If you are being seen for an urgent problem and do not feel as if you will be able to fulfill your financial obligation, please request to speak with a member of the billing staff, **prior to services being rendered,** to make financial arrangements.

If there are any problems with your insurance claims, our billing staff will make every effort to reconcile your account accordingly. If you fail to comply with any requested information or forms required by your insurance carrier, the balance of the claim(s) in question will ultimately be your responsibility.

Filing your insurance claim is a courtesy to you provided by our office. If you have medical insurance, it should be understood that this is an agreement between you and your insurance carrier to pay for medical care. If we are contracted with your insurance carrier, we will file your claim for you. If we are not contracted with your insurance carrier, payment is due at time of service. You are ultimately responsible for your bill regardless of the status of your insurance claim.

You will receive regular statements from our office informing you of the status of your balance. Please feel free to call the office with any questions. If we have not received any payment on your account after 90 days from the date of service, we reserve the right to refer your account to an outside collection agency where you will be responsible for all collection and legal fees. An in-house collection fee may apply.

If your account becomes delinquent, this will hinder our ability to provide medical care. This includes any physician services, lab services and prescription refills. Please make every effort to adhere to these policies to avoid any disruption in your healthcare with our office.

There will be a fee for all returned checks. If a check is returned on your account for non-sufficient funds, we will no longer be able to accept checks from you, no exceptions.

You will be billed separately by the hospital, lab, or other sources for certain lab fees, radiology fees, and/or outpatient and inpatient procedures. Please understand that we are not owned by Prisma Health Tuomey or any of its affiliates. Any previous financial agreements with that organization do not apply with our office.

Please feel free to speak with a member of our billing staff with any questions or concerns regarding our financial policies.

"I have read and understand the Financial Policy for Magnolia Family Practice, LLC."

_____ _____/_____/_____

↑ Signature of patient or legal guardian ↑ **Date**