Magnolia Medical Clinic, P.A.

319 Green Acres Rd Ste 101
Fort Walton Beach, FL 32547

Patient Information Date_____

Patient's Name _____
Date of Birth _____ Sex: ❑ Male ❑ Female
Social Security Number _____-_____-_____
Marital Status: Single Married Divorced Widowed
Race _____
Ethnicity: ❑ Latino/Hispanic ❑ Not Hispanic/Latino ❑ Other
Street Address_____
City _____ St. _____ Zip _____
Home phone (_____) _____
Cell phone (_____) _____
Email ___ _____
Preferred method of communication:
❑ Text ❑ Email ❑ Call - ❑ Home ❑ Cell ❑ Work

Employer _____
Street Address_____
City _____ St. ____ Zip _____
Phone (_____) _____
Occupation _____
Emergency Contact Name _____
Phone (_____) _____
Relation to contact _____

Primary Physician: ❑ Dr. Sites ❑ Dr. Pappas ❑ Dr. Skojac
❑ Dr. Paulson ❑ Dr. Zachary ❑ Dr. McDevitt
Referred by: _____

Guarantor (responsible party for bill)

Name _____
Mail Address _____
City _____ St. _____ Zip _____
Phone – Home (____) _____ Cell (____) _____
Relationship to patient _____ DOB _____

Social Security _____-_____-_____
Employer _____
Address _____
City _____ St. ____ Zip _____
Phone (_____) _____

Nearest Relative (Outside Household)

Name _____
Mail Address _____
City _____ St. _____ Zip _____

Phone (_____) _____
Relationship to patient_____

Medical Insurance

Primary Insurance
Company Name _____
Mail Address _____
City _____ St. _____ Zip _____
Phone (_____) _____
Insured/Subscriber Name _____
Insured/Subscriber DOB _____
Relationship to patient _____
Policy Number _____
Group _____
Effective Dates _____ to _____

Secondary Insurance
Company Name _____
Mail Address _____
City _____ St. ____ Zip _____
Phone (_____) _____
Insured/Subscriber Name _____
Insured/Subscriber DOB _____
Relationship to patient _____
Policy Number _____
Group _____
Effective Dates _____ to _____

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Insurance Assignment and Authorization Form

Magnolia Medical Clinic, P.A. is pleased to file insurance for our patients. In order to process your insurance claims, the patient or responsible party is responsible for providing the most current address, phone number, and insurance information at the time of service.

_____ (Initial) I authorize payment directly to Magnolia Medical Clinic, P.A. of insurance benefits that may be otherwise payable to me by my insurance company (ies). I hereby transfer to Magnolia Medical Clinic, P.A. my right to payment from any insurance company (ies) that is/are responsible for my charges on this account.

Statement of Financial Responsibility

_____(Initial) I acknowledge that I am responsible for all charges for Magnolia Medical Clinic, P.A. services provided to me, whether insured in the past or future, including any amount not paid and/or not covered by insurance or other third party payers, excluding contractual insurance adjustments. I understand that Magnolia Medical Clinic, P.A. will not accept responsibility for collecting insurance or negotiating the settlement of a disputed insurance claim. I agree to pay the charges for care provided to the patient by Magnolia Medical Clinic, P.A. at time of service. Should collection action become necessary, I agree to pay reasonable attorney fees, expenses and court costs incurred by Magnolia Medical Clinic, P.A.

_____ (Initial) I have read and understand the terms stated above. The terms and conditions constitute my complete agreement and may be modified only by written agreement signed by an authorized official of Magnolia Medical Clinic, P.A. I acknowledge receipt of a copy of this agreement.

Medicare Patients

_____ (Initial) I request that payment of authorized Medicare benefits be made either to me or on my behalf to Magnolia Medical Clinic, P.A. for any service furnished to me by physicians of Magnolia Medical Clinic, P.A.. I authorize release to the Centers for Medicare and Medicaid Services and its agents any medical information about me needed to determine payments for related services.

I, the undersigned, certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. I give my consent to Magnolia Medical Clinic, P.A. to use and disclose information about me for the purposes described in this form. I understand that I can withdraw this consent, in writing at any time except where you have already used or disclosed information in reliance on my prior consent.

_____ _____

Patient Name Date of Birth

_____ _____

Signature Date

*If patient is under 18 or unable to sign, representative must sign below.

*Reason for representative signature:

❑ Patient under 18 ❑ Physical disability ❑ Other: _____

_____ _____

Representative Name Relationship to patient

_____

Representative Address

_____ _____

Representative Signature Date

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Authorization for Disclosure of Health Information

Patient's Name: _____

Date of Birth: _____ Phone: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

1. I authorize the use of disclosure of the above named individual's health information as described below.
2. The following organization is authorized to make the disclosure:

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3. The type and amount of information to be used or disclosed is as follows: (include dates when appropriate)

_____ Complete health records
_____ Physical Exam
_____ Immunization Record
_____ Lab results/X-ray reports
_____ Consultation reports
_____ Other (please specify): _____

_____

4. I understand that the above information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

Name: _____ DOB: _____ Name: _____ DOB: _____
Name: _____ DOB: _____ Name: _____ DOB: _____
Name: _____ DOB: _____ Name: _____ DOB: _____
Name: _____ DOB: _____ Name: _____ DOB: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____

7. If I fail to specify an expiration date, event or condition, this authorization will expire one year from the signature date unless renewed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:
Melinda Maltby, Privacy Officer for Magnolia Medical Clinic, P.A.

_____ _____
Signature of patient or legal representative Signature of witness

Date: _____ Date: _____

RENEWAL INFORMATION

Date	Signature	Witness	Date

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ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I acknowledge that I have received a Notice of Privacy Policy from Magnolia Medical Clinic, P.A. I understand that if I have questions or complaints that I should contact the Privacy Official at 850-243-7681. I understand that I have the right to request that you restrict how information about me is used or disclosed for treatment, payment, or healthcare operations. I understand that you are not required to agree with these restrictions, but if you do, you are bound by the restrictions.

Patient Name (Please PRINT): _____

Signature: _____ Date: _____

Witness: _____

I am a personal representative/parent (please circle one) for the following patient and/or patients in this practice. I acknowledge that the Notice of Privacy Policies that I received is for the following: (List First and Last Name and Date of Birth)

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Name (Please PRINT): _____

Signature: _____

Date: _____

Witness: _____

FOR OFFICE USE ONLY

We attempted, in good faith, to obtain written acknowledgement of receipt of our Privacy Policy, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgment
- ❑ An emergency prevented us from obtaining acknowledgment
- ❑ Other (Please explain below)

_____

_____

_____

_____

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Appointment Reminders

Our patient communication system is designed to ensure confirmation of your appointment. Please take the time to confirm your appointment via text message or by phone call when prompted. If the system does not reach you, our office will attempt to contact you one final time, unconfirmed appointments may be cancelled. If you are unable to keep your appointment, please notify our office at least 24 hours in advance at (850)243-7681 to reschedule. Please understand that when a patient does not keep their appointment, we lose that time that could have been dedicated to another patient who needed care. Multiple no shows can and will lead to your dismissal.

Checking In

New patients must arrive 45 minutes prior to your appointment and all others must arrive at least 15 minutes prior. If you are more than 20 minutes late for your appointment, you may be asked to reschedule. Upon arrival, a patient services representative may ask you to complete some paperwork and verify your current information.

Payment of services

Payment is due at the time of service. Your co-payment and any outstanding balance will be collected prior to your visit. Deductibles, co-insurance, and self-pay payments are to be paid at the front desk prior to and following your appointment.

Prescriptions

New prescriptions will be sent to your pharmacy following your appointment. Please contact **your Pharmacy** for all your prescription refills. We require **72** hours to process your requests. If your Pharmacy has not notified you that your refill is ready after 72 hours, please contact us during the normal business hours of 8:00am – 5:00pm, Monday through Friday. Prescription refills are not considered an emergency.

Medical Records

All medical records request are handled through SHARECARE imaging. SHARECARE will charge an upfront fee for copying in accordance with state law which is $1.00/page for pages 1-25 and $.25 for each additional page. There is no charge for records delivered to another healthcare provider for ongoing treatment. To initiate your request, complete a Medical Records Release form. You can contact a SHARCARE representative at any time by calling 1-877-391-9890. Processing of your request takes approximately 10 business days.

Medical Records Authorization

Protected Health Information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, unless specifically excluded under the Health Insurance Portability and Accountability Act (HIPAA).

Laboratory Hours

Scheduled labs 7:30am- 4:00pm

Radiology

All x-ray films are stored at our storage facility. Any questions regarding x-rays may be addressed by calling our main number at (850) 243-7681.

Treatment of Minors

A parent or legal guardian must accompany new patients under the age of 18 at their initial visit. The parent or legal guardian may designate someone to accompany an existing patient during follow-up visits if it is specified on a Minor's Consent for Treatment form. This form can be obtained at the check-in area.