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. Pappas ❑ Dr.Skojac ❑ Dr.Paulson
❑ Dr. Zachary ❑ Dr. McDevitt ❑ Dr. Loudermilk

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 _____

Magnolia Medical Clinic, P.A.

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

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

Magnolia Medical Clinic, P.A.
319 Green Acres Rd Ste 101
Fort Walton Beach, FL 32547

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:

Magnolia Medical Clinic, P.A.
319 Green Acres Rd Ste 101
Fort Walton Beach, FL 32547

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

Magnolia Medical Clinic, P.A.

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

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)

_____
_____
_____
_____

Magnolia Medical Clinic, P.A.
319 Green Acres Rd Ste 101
Fort Walton Beach, FL 32547

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.

PATIENT HISTORY

Name _____ DOB Age _____ Single Married Divorced Widow(er) Date _____

Occupation _____ All previous occupations _____ Religion _____

Birth Place _____ Name of Spouse _____

Education: Years Completed _____ High School. _____ College. _____ Post Grad. _____ Highest Degree Obtained

Do you have a Living Will? Yes ☐ No ☐

Date of last physical examination _____

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

FAMILY HISTORY	If Living Age	If Living Health	If Deceased Age at death	If Deceased Cause
Father				
Mother				
Siblings (B/S)				
(B/S)				
(B/S)				
(B/S)				
(B/S)				
Husband or Wife				
Children (S/D)				
(S/D)				
(S/D)				
(S/D)				
(S/D)				
(S/D)				

Has any blood relative ever had :	Please circle No or Yes		Relationship
Heart Attack	no	yes	
Diabetes	no	yes	
Cancer	no	yes	
Stroke	no	yes	
Mental Illness	no	yes	
Suicide	no	yes	
Other	no	yes	

PERSONAL HISTORY

MEDICAL:

MEDICATIONS:

ALLERGIES: No ☐ Yes ☐

You are allergic to . . .

List Drug Allergies

List Food Allergies

List Any Other Allergies

INJURIES: have you had any

Broken or cracked bones _____ no yes

Lacerations (Severe) _____ no yes

Dislocations _____ no yes

Concussion, or head injury _____ no yes

WEIGHT: now _____, one year ago _____

Maximum _____, when _____

TRANSFUSIONS: have you ever had

Blood or Plasma transfusion _____ no yes

Date _____

SURGERY: Have you had

Tonsillectomy _____ no yes

Appendectomy _____ no yes

Any other operation _____ no yes

Procedure _____ Year _____

Procedure _____ Year _____

Procedure _____ Year _____

Procedure _____ Year _____

Colonoscopy no yes Date _____

Have you ever been advised to have any surgical operation which has not been done _____ no yes

Have you been hospitalized for any illness _____ no yes

Give details :

Please Turn Page Over

RADIOLOGY STUDIES: Have you ever had x-rays of

CT _____ no yes

MRI _____ no yes

Date of last Dexascan _____

IMMUNIZATIONS: Have you had

Tetanus shots (not antitoxin which lasts only 2 weeks) no yes

Date of most recent Tetanus _____

Flu Vaccine _____ no yes

Pneumonia Vaccine _____ no yes

Hepatitis A _____ no yes

Hepatitis B _____ no yes

Other _____ no yes

SYSTEMS: Do you now have or have you ever had (of significance)

Any eye disease, injury, impaired sight _____ no yes

Any ear disease, injury, impaired hearing _____ no yes

Any trouble with nose, sinuses, mouth, throat _____ no yes

Fainting spells _____ no yes

Loss of consciousness/Concussion _____ no yes

Convulsions _____ no yes

Paralysis _____ no yes

Dizziness _____ no yes

Frequent or severe headaches _____ no yes

Depression or anxiety _____ no yes

Hallucinations _____ no yes

Enlarged glands _____ no yes

Thyroid disease or goiter _____ no yes

Skin Disease _____ no yes

Chronic or frequent cough _____ no yes

Chest pain or angina pectoris _____ no yes

Spitting up blood _____ no yes

Night sweats _____ no yes

Shortness of breath _____ no yes

Heroic Snoring _____ no yes

Apnea while sleeping _____ no yes

Palpitation or fluttering heart _____ no yes

Swelling of hands, feet, or ankles _____ no yes

Varicose veins _____ no yes

Extreme tiredness or weakness _____ no yes

Kidney disease or stones _____ no yes

Difficulty in urinating _____ no yes

Abnormal thirst _____ no yes

Stomach trouble or ulcer _____ no yes

Indigestion _____ no yes

Liver or gall bladder disease _____ no yes

Colitis or other bowel disease _____ no yes

Hemorrhoids or rectal bleeding _____ no yes

Constipation or Diarrhea _____ no yes

Has there been any recent change in -

Your appetite or eating habit _____ no yes

Your bowel action or stools _____ no yes

HABITS:

Exercise adequately? _____ yes no

How? _____

Sleep well? _____ yes no

Do you snore excessively, stop breathing during sleep

or have daytime drowsiness? _____ no yes

Alcoholic beverages: never ☐ rarely ☐ moderate ☐ daily ☐

Have you ever been treated for alcoholism _____ no yes

Tobacco: Cigarettes _____ packs per day currently

Cigars ☐ Pipe ☐ Chewing Tobacco ☐ Snuff ☐

Ever smoked _____ no yes

How many years _____

Illicit Drugs: _____

Sex – entirely satisfactory? _____ yes no

Work _____ hrs. per day – indoors ☐ outdoors ☐

Do you like your work? _____ no yes

Recreation:

Do you participate in sports or have

any hobbies? _____ no yes

_____

_____

WOMEN ONLY

Menstrual History

Age at onset _____

Regular – yes ☐ no ☐

Cycle – _____ days (from start to start)

Usual duration – _____ days

Heavy ☐ Medium ☐ Light ☐

Pains or cramps – yes ☐ no ☐

date of last period _____

date of last mammogram _____ Last PAP _____

Pregnancies

How many children born alive _____

How many stillbirths _____

How many prematures _____

How many Cesarean Sections _____

How many miscarriages _____

Any complications with any pregnancy _____ no yes

MEN ONLY

Date of last PSA test _____

Magnolia Medical Clinic
Family Medicine

Phone (850) 243-7681
Fax (850) 243-0471
319 Green Acres Road
Suite 101
Fort Walton Beach, FL 32547

Chris G. Pappas, M.D., F.A.A.F.P.
Teresa M. Skojac, M.D., M.P.H.
Christopher P. Paulson, M.D., F.A.A.F.P.
Grant E. Zachary III, M.D., F.A.A.F.P.
Emily McDevitt, D.O., F.A.A.F.P.
John E. Loudermilk, M.D., F.A.A.F.P.
Andrea Walter, A.R.N.P.

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Magnolia Medical Clinic, P.A. When you schedule an appointment with Magnolia Medical Clinic, P.A we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, but no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective April 1, 2022, any established patient who fails to show or cancels an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged a **$25.00 fee**.
- Any established patient who fails to show or cancels an appointment without **24 hours notice** a **second** time will be charged a second **$25.00 fee**.
- If a **third** No Show or cancellation without **24 hours notice** should occur the patient may be dismissed from Magnolia Medical Clinic, P.A.
- Any new patient who fails to show for their **initial visit** will not be permitted to be rescheduled.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**. Magnolia Medical Clinic, P.A will not see a patient if the No Show fee is not paid prior to your next visit.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager Crystal Weatherington, who may be able to waive the No Show fee. You may contact Magnolia Medical Clinic, P.A 24 hours a day, 7 days a week at the number below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____
Signature (Parent/Legal Guardian)

_____
Relationship to Patient

_____
Printed Name

_____
Date