MAGNOLIA
HEALTH

Patient Demographic Information

*Fields with * are required*

PATIENT INFORMATION

Last name*: _____ **First name*:** _____ **Middle initial:** _____

If minor, name of responsible parent: _____

Name you would like to appear on your health records: _____

What are your pronouns: ☐ He/him ☐ She/her ☐ They/them ☐ Other: _____

DOB*: _____ **Social Security#*:** _____ **Drivers license #*:** _____

Home address*: _____ **APT/suite #:** _____

City*: _____ **State*:** _____ **ZIP*:** _____

Pick one: **Home #*:** ☐ _____ **Mobile #*:** ☐ _____ (Checkmark the best number to use)

Email address*: _____

Do you think of yourself as:

☐ Male ☐ Female ☐ Transgender man/trans man ☐ Transgender woman/trans woman
☐ Genderqueer/gender nonconforming, neither exclusively male nor female
☐ A category not listed here, please specify: _____ ☐ Decline to answer

Do you think of yourself as:

☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Queer, pansexual and/or questioning
☐ An orientation not listed here, please specify: _____ ☐ Don't know ☐ Decline to answer

Occupation: _____

Employer: _____

Phone #: _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

EDUCATION, LANGUAGE & DEMOGRAPHICS

Highest level of education: _____

Preferred language: _____ **Do you need an interpreter?:** _____

Ethnicity: _____ **Race:** _____

IF APPLICABLE, NAME OF SPOUSE/DOMESTIC PARTNER

Last name: _____ **First name:** _____ **Middle initial:** _____

IF THE PATIENT IS LIVING IN A NURSING OR ASSISTED LIVING FACILITY*

Name of facility*: _____

Address*: _____ **Room #*:** _____

City*: _____ **State*:** _____ **ZIP*:** _____

CONTACT INFORMATION FOR RESPONSIBLE PARTY/SPOUSE/PARENT (If info same as above, leave blank)

Last name: _____ **First name:** _____ **Middle initial:** _____

Social security #: _____ **Relationship to patient:** _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Home #: _____ **Cell #:** _____ **Email address:** _____

EMERGENCY CONTACTS (PLEASE PROVIDE TWO WITH DIFFERENT CONTACT INFORMATION)			
Name		**Relationship**	**Phone #**
Address	**City**	**State**	**ZIP**
Name		**Relationship**	**Phone #**
Address	**City**	**State**	**ZIP**

Patient signature: _____ **Date:** _____

Patient representative/parent: _____ **Date:** _____

For patients requiring translation or verbal reading of the document, the reader or translator may document and sign below.

Reader/translator: _____ **Date:** _____

Billing Information & Responsible Party/Insurance Information

Last name: _____ **First name:** _____ **Middle initial:** _____

INSURANCE INFORMATION	
Primary insurer*	**Name of insured***
Insurance ID# / Group # / Other information	
Secondary insurer*	**Name of insured***
Insurance ID# / Group # / Other information	
Tertiary insurer*	**Name of insured***
Insurance ID# / Group # / Other information	
Pharmacy insurer*	**Name of insured***
Insurance ID# / BIN # / PCN # / Group # / Other information	

Patient signature: _____ **Date:** _____

MAGNOLIA
HEALTH

Health History

Last name: _____ **First name:** _____ **DOB:** _____

List any specific concerns for your visit today:

_____

_____

_____

Personal Medical History

Constitutional *e.g., fever, heat stroke, weight loss, weight gain, unusually tired, etc.*

☐Yes ☐No

Comments: _____

Ear/Nose/Throat *e.g., hard of hearing, stuffy nose, earache, cough, dry mouth, etc.*

☐Yes ☐No

Comments: _____

Heart (Cardiovascular) *e.g., high blood pressure, racing pulse, chest pain, unable to exercise, etc.*

☐Yes ☐No

Comments: _____

Lungs (Respiratory) *e.g., congestion, wheezing, shortness of breath, productive or bloody cough, asthma, etc.*

☐Yes ☐No

Comments: _____

Digestion (Gastrointestinal) *e.g., stomach upset, diarrhea, constipation, hernia, ulcers, pain/cramps, acid reflux, etc.*

☐Yes ☐No

Comments: _____

Muscles and bones (Musculoskeletal) *e.g., muscle pain/cramps, joint pain swelling, stiffness, etc.*

☐Yes ☐No

Comments: _____

Urological *e.g., painful or frequent urination, burning, impotence, incontinence, infections, etc.*

☐Yes ☐No

Comments: _____

Gynecological *e.g., pregnancies, menstrual problems, ovarian and uterine conditions, etc.*

☐Yes ☐No

Comments: _____

Breast *e.g., cysts, fibroids, pain, numbness, lumps, etc.*

☐Yes ☐No

Comments: _____

Neurological *e.g., numbness, weakness, headaches, paralysis, seizures, tremors, tingling, etc.*

☐Yes ☐No

Comments: _____

Psychiatric *e.g., depression, anxiety, mood swings, insomnia, hallucinations, disorientation, etc.*

☐Yes ☐No

Comments: _____

Blood/Lymphatic *e.g., high cholesterol, anemia, blood disorders, leukemia, prolonged bleeding, etc.*

☐Yes ☐No

Comments: _____

Skin *e.g., itching, rash, infection, ulcer, tumors or growths, warts, excessive dryness, etc.*

☐Yes ☐No

Comments: _____

Cancer

☐Yes ☐No

Comments: _____

Allergic/Immunologic *e.g., recurrent infections, hay fever, food allergy, drug sensitivity, hives, redness, itching, etc*

☐Yes ☐No

Comments: _____

Hormones (Endocrine) *e.g., diabetes, thyroid problems, fatigue, hair loss, hot/cold intolerance, etc.*

☐Yes ☐No

Comments: _____

IF DIABETIC:

Doctor and contact information: _____

Year of diagnosis: _____ **Result/Time of last blood sugar:** _____

Last hemoglobin A1C: _____ **Treatments:** _____

Major illnesses/Hospitalizations

☐Yes ☐No

Comments: _____

Surgeries

☐Yes ☐No

Comments: _____

Family History
(Parents, Siblings, or Grandparents only)

Systemic Disease	
☐Diabetes ☐Cancer ☐Heart disease	☐Hypertension ☐Arthritis ☐Other:

PERSONAL SOCIAL HISTORY

Marital status: _____

Living arrangements: _____

Have you been exposed to venereal disease/sexually transmitted infection?

☐Yes ☐No

Are you pregnant?

☐Yes ☐No

Occupation(s): _____

Occupational exposure:

☐Yes ☐No

Recent travel:

☐ Yes ☐ No

Tobacco use

☐Never ☐Current everyday use ☐Current intermittent use ☐Former use ☐Status unknown ☐Other: _____

Alcohol use

☐Never ☐Current everyday use ☐Current intermittent use ☐Former use ☐Status unknown ☐Other: _____

Recreational drug use

☐Never ☐Current everyday use ☐Current intermittent use ☐Former use ☐Status unknown ☐Other: _____

Medications: *List ALL medications you are CURRENTLY taking. (Include all herbals, vitamins and supplements)*

Name	Dose	Frequency	Other information

IF MEDICATION LIST GOES BEYOND THE SPACE PROVIDED, THEN PLEASE ATTACH A SEPARATE

Allergies: *Please list ALL allergies*

Allergy	Severity	Reaction	Treatment Information

Preferred pharmacy:

Name	Pharmacy Location Number	Address	Phone Number	Fax Number

Signature _____ **Date** _____

Printed name _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION PURSUANT TO FEDERAL REGULATIONS. PLEASE REVIEW IT CAREFULLY.

At Magnolia Health, PLLC ("Practice"), we understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive directly from one of our providers. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice of Privacy Practices ("Notice") applies to all the records of your care generated by our practice.

This notice will tell you about the ways in which the practice may use and disclose your protected health information ("PHI"). This Notice also describes your rights and certain obligations the practice has regarding the use and disclosure of PHI.

REGULATORY REQUIREMENTS.
Magnolia Health, PLLC is required by law to maintain the privacy of your PHI, to provide individuals with notice of our practice's legal duties and privacy practices with respect to PHI, and to abide by the terms described in the notice currently in effect.

RIGHTS.
You have the following rights regarding your PHI:

Restrictions.
You may request that the practice restrict the use and disclosure of your PHI. To request restrictions, you must make your request in writing to our Privacy Officer using the applicable practice form. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the restrictions to apply, for example, disclosures to your spouse.

Alternative Communications.
You have the right to request that communications of PHI to you from Magnolia Health, PLLC be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, instead of your home address. Your requests must be made in writing using our practice form and sent to the Privacy Officer. Magnolia Health, PLLC will accommodate your reasonable requests.

Inspect and Copy.
Generally, you have the right to inspect and copy your PHI that Magnolia Health, PLLC maintains, provided you make your request in writing to Practice's Privacy Officer. If you request copies of your PHI, we may impose a reasonable fee to cover copying and postage. If we deny access to your PHI, we will explain the basis for denial and your opportunity to have your request and the denial reviewed by a licensed health care professional (who was not involved in the initial denial decision) designated as a reviewing official. If Magnolia Health, PLLC does not maintain the PHI you request and if we know where that PHI is located, we will tell you how to redirect your request.

Amendment.
If you believe that your PHI maintained by Magnolia Health, PLLC is incorrect or incomplete, you may ask us to correct your PHI. Your request must be made in writing, and it must explain why you are requesting an amendment to your PHI. We can deny your request if your request relates to PHI: (i) not created by the practice; (ii) not part of the records Practice maintains; (iii) not subject to being inspected by you; or (iv) that is accurate and complete. If your request is denied, we will provide you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial; (ii) if you do not file a statement of disagreement, submit a request that any future disclosures of the relevant PHI be made with a copy of your request and the practice's denial attached; and (iii) complain about the denial.

Accounting of Disclosures.
You generally have the right to request and receive a list of the disclosures of your PHI we have made at any time during the six (6) years prior to the date of your request (provided that such a list would not include disclosures made prior to April 14, 2003). The list will not include disclosures made at your request, with your authorization, and does not include certain uses and disclosures to which this Notice already applies, such as those: (i) for treatment, payment and health care operations; (ii) made to you; (iii) for

Magnolia Health, PLLC patient list; (iv) for national security or intelligence purposes; or (v) to law enforcement officials. You should submit any such request to Practice's Privacy Officer. Practice will provide the list to you at no charge, but if you make more than one request in a year you will be charged a fee of the costs of providing the list.

Right to Copy of Notice.
You have the right to receive a paper copy of this notice upon request. To obtain a paper copy of this notice, please contact the Privacy Officer at the address and contact information stated at the end of this notice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.
Magnolia Health, PLLC may use or disclose your PHI for the purposes described below **without obtaining written authorization from you**. In addition, Magnolia Health, PLLC and the members of its medical and allied health professional staff who participate in the organized health care arrangement described below may share your PHI with each other as necessary to carry out their treatment, payment, and health care operations related to the organized health care arrangement.

For Treatment.
Magnolia Health, PLLC may use and disclose PHI while providing, coordinating, or managing your medical treatment, including the disclosure of PHI for treatment activities of another health care provider.

For Payment.
Magnolia Health, PLLC may use and disclose PHI to bill and collect payment for the health care services provided to you. For example, the practice may need to give PHI to your health plan to be reimbursed for the services provided to you. Th practice may also disclose PHI to its business associates, such as billing companies, claims processing companies, and others that assist in processing health claims. Magnolia Health, PLLC may also disclose PHI to other health care providers and health plans for the payment activities of such providers or health plans.

For Health Care Operations.
Magnolia Health, PLLC may use and disclose PHI as part of its operations, including for quality assessment and improvements, such as evaluating the treatment and services you receive and the performance of staff and physicians in caring for you, patient surveys, provider training, underwriting activities, compliance and risk management activities, planning and development, credentialing and peer review activities, and health care fraud and abuse detection or compliance, and management and administration. The practice may disclose PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants and others for review and learning purposes, to help make sure Magnolia Health, PLLC is complying with all applicable laws, and to help Practice continue to provide quality health care to its patients.

As Required by Law and Law Enforcement.
Magnolia Health, PLLC may use or disclose PHI when required to do so by applicable laws and when ordered to do so in a judicial or administrative proceeding. The practice may also use or disclose PHI upon a properly documented and limited request from law enforcement agencies.

For Public Health Activities and Public Health Risks.
Magnolia Health, PLLC may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, or notifying a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

For Health Oversight Activities.
Magnolia Health, PLLC may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure, or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs and compliance with civil rights laws.

Coroners, Medical Examiners and Funeral Directors.
Magnolia Health, PLLC may disclose PHI to coroners, medical examiners and funeral directors for the purpose of identifying a decedent, determining a cause of death or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

Research.
Under certain circumstances, Magnolia Health, PLLC may use and disclose PHI for medical research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication with those who received another, for the same condition.

To Avoid a Serious Threat to Health or Safety.
Magnolia Health, PLLC may use and disclose PHI to law enforcement personnel or other appropriate persons to prevent or lessen a serious threat to the health or safety of a person or the public.

Specialized Government Functions.
Magnolia Health, PLLC may use and disclose PHI of military personnel and veterans under certain circumstances. The practice may also disclose PHI to

authorized federal officials for intelligence, counterintelligence, and other national security activities, and for the provision of protective services to the president or other authorized persons or foreign heads of state or to conduct special investigations.

Disclosures to You or for HIPAA Compliance Investigations.
Magnolia Health, PLLC may disclose your PHI to you or to your personal representative and is required to do so in certain circumstances described below in connection with your rights of access to your PHI and to an accounting of certain disclosures of your PHI. The practice must disclose your PHI to the secretary of the United States Department of Health and Human Services (the "Secretary") when requested by the Secretary in order to investigate the practice's compliance with privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996.

Patient List; Marketing.
Unless you object, Magnolia Health, PLLC may use some of your PHI to maintain a list of patients it has served. This information may include your name, treatment facility, and the services provided to you. This patient list and the information on it may be used for marketing purposes.

Disclosures to Individuals Involved in Your Health Care or Payment for Your Health Care.
Unless you object, Magnolia Health, PLLC may disclose your PHI to a family member, other relative, friend, or other person you identify as involved in your health care or payment for your health care.

OTHER USES AND DISCLOSURES.
Other types of uses and disclosures of your PHI not described above will be made only with your written authorization, which with some limitations; you have the right to revoke your authorization in writing. If you revoke your authorization, the practice will no longer use or disclose PHI about you for the reasons covered in your written authorization. Please understand that the practice is unable to recover any disclosures already made with your authorization, and that the practice is required to retain records of the care provided to you.

RIGHT TO FILE A COMPLAINT.
At Magnolia Health, PLLC, we value the relationships we develop with our patients, our patients' privacy, and the trust our patients' have in us. As such, we make every effort to remedy any issues or concerns you may have. You may submit any complaint regarding your privacy rights to:

Justin Moore, Practice Administrator

127 East Trade Street, Suite B100
Forest City, NC 28043
(828) 220-4174

You also have the right to file a complaint with the secretary of the Department of Health and Human Services, Office for Civil Rights. You will not be penalized for filing a complaint. You may contact the Office for Civil Rights at:

Office for Civil Rights
U.S. Department of Health and Human Services
Information for regional offices

PLEASE CONTACT THE PRIVACY OFFICER IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE OF PRIVACY PRACTICES OR YOUR PRIVACY RIGHTS.

MAGNOLIA
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Acknowledgment of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand the *Notice of Privacy Practices* document containing a more complete description of the uses and disclosures of my health information. I understand that Magnolia Health, PLLC ("Practice") has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below for a current copy of the *Notice of Privacy Practices* document.

Patient name	Signature	Date
Name/relationship to patient	Signature	Date

FOR OFFICE USE ONLY

Practice provided the above-referenced patient with the Practice's Notice of Privacy Practices and this Acknowledgment of Receipt of Notice of Privacy Practices, but could not obtain a signed acknowledgment form because:

☐ Patient or guardian refused to sign

☐ Emergency situation

☐ Other: _____

MAGNOLIA
HEALTH

Practice Financial Policy

Thank you for choosing Magnolia Health, PLLC as your health care provider. We are committed to building a successful provider-patient relationship, and the success of your medical treatment and care. Your understanding of our Practice Financial Policy and payment for services are important parts of this relationship. For your convenience, this document discusses a few commonly asked financial policy questions. If you need further information or assistance about any of these policies, please ask to speak with our Practice Manager.

When are payments due?
All co-payments, deductibles, patient responsibility amounts, and past-due balances are due at the time of check-in unless previous arrangements have been made with our billing coordinator.

How may I pay?
We accept payment by cash, VISA, and MasterCard.

Do I need a referral or pre-authorization?
If your insurance plan requires a referral authorization from your primary care physician or a pre-authorization from your insurance, you will need to contact your primary care physician or insurance company to be sure it has been obtained. If we have yet to receive authorization prior to your appointment time, we will reschedule. Failure to obtain the referral or pre-authorization may result in a lower or no payment from the insurance company, and the balance will become the patient's responsibility.

Will you bill my insurance?
Insurance is a contract between you and your insurance company. In most cases, we are not a party to this contract. We will bill your primary insurance company on your behalf as a courtesy to you. To properly bill your insurance company, we require that you disclose all insurance information, including primary and secondary insurance, as well as any change of insurance information.

It is your responsibility to notify our office promptly of any patient information changes (i.e., address, name, insurance information) to facilitate appropriate billing for the services rendered to you. Failure to provide complete and accurate insurance information may result in the entire bill being categorized as a patient's responsibility.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Which plans do you contract with?
Magnolia Health, PLLC accepts most major insurance plans. However, with the frequent changes that happen in the insurance marketplace, it is a good idea for you to contact your insurance company prior to your appointment and verify if we are a participating provider as per your plan.

What if my plan does not contract with you?
If we are not a provider under your insurance plan, you will be responsible for payment in full at the time of service. As a courtesy, however, we will file your initial insurance claim, and if not paid within 45 days, you will be responsible for the total bill. After your insurance company has processed your claims, any amount remaining as a credit balance will be refunded to you.

What is my financial responsibility for services?
It is your responsibility to verify that the physicians and the practice where you are seeking treatment are listed as authorized providers under your insurance plan. Your employer or insurance company should be able to provide a current provider listing.

If you have:

Workers' Compensation

- *If we have verified the claim with your carrier*: No payment is necessary at the time of the visit.
- *If we are not able to verify your claim*: Your appointment will need to be rescheduled.

Our staff will schedule your appointment after your worker's compensation carrier calls in advance to verify the accident date, claim number, primary care physician, employer information, and referral procedures.

Workers' Compensation (Out of State) and Occupational Injury

- Payment in full is requested at the time of the visit.

Our staff will provide a receipt to file the claim with your carrier.

The patient or the patient's legal representative is ultimately responsible for all charges for services rendered. "Non-covered" means that a service will not be paid for under your insurance plan. If non-covered services are provided, you will be expected to pay for these services at the time they are provided or when you receive a statement or explanation of benefits (EOB) from your insurance provider denying payment.

Your insurance company offers appeal procedures. We will not under any circumstances falsify or change a diagnosis or symptom to convince an insurer to pay for care that is not covered, nor do we delete or change the content in the record that may prevent services from being considered covered. We cannot offer services without expectation of payment, and if you receive non-covered services, you must agree to pay for these services if your insurance company does not. If you are unsure whether a service is covered by your plan, ultimately, it is your responsibility to call your insurance company to determine what your schedule of benefits allows, if a deductible applies, and your potential financial responsibility.

What if I don't have insurance?
Self-pay accounts are used for patients without insurance coverage, patients covered by insurance plans which the office does not accept, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating in their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to pay in full for services rendered to them and will be asked to make payment arrangements prior to services being rendered. Emergency services provided to self-pay patients will be billed to the patient.

At the sole discretion of the practice, extended payment arrangements may be made for patients. Please speak with our practice manager to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and reasonable costs.

I received a bill even though I have secondary insurance.
Having secondary insurance does not necessarily mean that your services are 100% covered. Secondary insurance policies typically pay according to a coordination of benefits with the primary insurance.

What if I have billing or insurance questions?
Magnolia Health, PLLC is supported by a staff of dedicated professionals. Our office staff can assist with most financial questions and help relieve the patient/caregiver of burdensome paperwork. Please ask if you have any questions about our fees, our policies, or your responsibilities.

Do you bill workers' compensation?
We will bill workers' compensation for verified claims. It is the patient's responsibility to provide our office staff with employer authorization and contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then becomes the patient's responsibility.

At your request, we will submit the claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your primary medical insurance carrier's claim is denied, you will be responsible for payment in full.

Do you bill other third parties?
We do not bill third parties for services rendered to you. Our relationship is with you and not with the third-party liability insurer or policy carrier (eg, auto or homeowner). It is your responsibility to seek reimbursement from them. However, at your request, we will submit a claim to your primary health insurance carrier. You will be asked to pay in full for the services we provide you. All formalities required by your insurer and the third party should be promptly completed by you. If we receive a denial of your claim, you will be responsible for payment in full.

What if my insurance pays late?
As a courtesy to you, we bill your insurance company for services on your behalf. If any insurance company fails to process payment for services within 45 days from the date of the claim submission, the total balance will be determined to be the patient's responsibility.

Will I receive statements or bills?
It is our office policy that all accounts with pending balances be sent two statements, each one month apart. If payment is not made on the account, a single phone call will be made to try and make payment arrangements. Accounts with unpaid balances for 90 calendar days or more will be sent to an external collection agency or attorney for collection. Unpaid bills can also lead to possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for the collections costs, including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office if you are 18 years old or older and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

Do you refer unpaid bills to collection agencies?
If a patient cannot pay the balance on their account according to the financial policy will be referred to an outside collection agency or an attorney for further action.

What if my child needs to see a provider?
A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages.

Do you charge a penalty for returned payments?
Any charges incurred by the practice collecting balances owed to us during the collection process may be charged to the patient. Returned checks, credit card charge backs, or returned payments will attract a minimum $40 penalty in addition to the balance owed. Accounts with returned payments will be expected to make payments via cash, money order, or cashier's checks only.

Can you waive my copay?
We cannot waive deductibles, coinsurances, or copays that are required by your insurance. This is a violation of insurance rules.

I have a hardship. How can you help me?
Some patients may accrue large balances for services provided. At the sole discretion of the practice leadership, we will work with you to set up a mutually feasible payment plan. In some cases, if the minimum payment due cannot be paid, we will need proof of financial hardship. We may be forced to pursue collections of balances in the absence of tangible proof of hardship.

Do you charge for completing forms?
Completing disability forms, FMLA forms, and other requested supplemental insurance forms requires time away from patient care and day-to-day business operations. A prepayment of $15.00 per form is required. Please understand that to complete forms, your medical record must be reviewed, forms completed and signed by the provider, and copied into your medical record. Some of these forms can be quite complicated and tedious to fill out. Please provide us with pertinent information, especially dates of disability and return to work. We request that you allow 7 business days for this process.

Do you charge for copies of medical records?
Patients requesting copies of their medical records will not be charged a fee.

Attorneys and Insurance companies requesting medical records will be charged a $15 fee plus postage and these fees:

- $0.25 per page – under 100 pages
- $0.10 per page – over 100 pages
- $15 for an itemized bill

Expedited requests will be charged a special handling fee of $50.

Records requested via electronic media (flash drives, CDs, DVDs, etc.) will be charged an additional $20 device fee.

What if I missed my appointment to see the physician?
We understand that on rare occasions, issues may arise, causing you to miss your appointment when you cannot notify our office before your appointment. Should you experience any unforeseen circumstance that causes you to miss your appointment, please call our office at least 24 hours prior to having it rescheduled.

Our highly skilled providers are committed to your well-being and have reserved time just for you. Patients who miss more than one appointment without notifying our office 24 hours before the appointment time are subject to a $50 missed appointment fee billed to the patient.

I have read, understand, and agree to the above Financial Policy. I understand my financial responsibility to make payments for services provided to me and the courtesy extended by Magnolia Health, PLLC to simplify insurance reimbursement for the services provided to me. I acknowledge that these policies do not obligate Magnolia Health, PLLC to extend credit to me for services provided.

Patient or authorized representative signature: _____

Patient or authorized representative name: _____

Date: _____

MAGNOLIA
HEALTH

Benefits Assignment and Financial Responsibility

Last name	First name	DOB
Address		SSN

RELEASE OF INFORMATION: I authorize Magnolia Health, PLLC to disclose and release to my insurance carrier(s), including Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies.

ASSIGNMENT OF BENEFITS: I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

AGREEMENT OF RESPONSIBILITY: I understand that **COPAYMENT IS DUE AT THE TIME OF SERVICE** (coinsurance and deductibles may also be collected at the time of service). I understand I am financially responsible for charges not covered by my insurance company. I also agree to pay any outstanding balance as well as attorney fees and costs to Magnolia Health, PLLC if this matter is referred to collection.

MEDICARE AUTHORIZATION: As a Medicare beneficiary, I understand my signature requests payment to be made and authorize the release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes the release of information to insurance companies or its authorized agents. In Medicare-assigned cases, the provider, or supplier, agrees to accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Patient signature: _____

Print name: _____

Date: _____

MAGNOLIA
HEALTH

Informed Consent for Telemedicine Services

Introduction

Telemedicine involves electronic communications to enable health care providers at various locations to share individual patients' medical information to improve patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up, and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits

Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.

More efficient medical evaluation and management.

Obtaining expertise of a distant specialist.

Possible Risks

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In exceedingly rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment errors.

By signing this form, I attest to and understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. Clayton Moore, FNP has explained the alternatives to my satisfaction,
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners located in other areas, including out of state.
6. I understand that it is my duty to inform Clayton Moore, FNP of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I attest that I am located in the state of North Carolina and will be present in the state of North Carolina during all telehealth encounters with Magnolia Health, PLLC.

I have read and understand the information provided above regarding telemedicine, have discussed it with my provider, or such assistants as may be designated, and all answered to my satisfaction. I hereby give my consent for the use of telemedicine in my medical care. I understand a paper copy of this form will be made available if requested.

I hereby authorize Magnolia Health, PLLC to use telemedicine in the course of my diagnosis and treatment.

Patient Name: _____

Signature: _____

Name/Relationship to Patient: _____

Date: _____

MAGNOLIA
HEALTH

CONSENT FOR TREATMENT

By this document, I do hereby request and authorize Magnolia Heath, PLLC (Magnolia Health Primary Care), its medical practices and providers, including physicians, technicians, nurses, and other qualified personnel, including appropriately supervised students and residents to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s).

I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations, or procedures.

TREATMENT OF MINOR CHILDREN:

I understand minor patients must be accompanied by a parent or legal guardian. Charges for services rendered to minor children are the responsibility of the guardian who seeks treatment for the child and are due at time of service(s) regardless of court-ordered responsibility.

PHOTOGRAPHY/VIDEO:

I acknowledge that my photograph may be taken for chart identification and documentation purposes for my electronic health record and is the property of Magnolia Health, PLLC (Magnolia Health Primary Care) unless I withdraw my consent in writing. I consent to videotaping for a telehealth appointment for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations. I understand and agree not to photograph, videotape, audiotape, record, or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

ELECTRONIC PRESCRIBING:

I understand that Magnolia Health, PLLC may use an electronic prescription system that allows prescriptions and related information to be electronically sent between Magnolia Health, PLLC providers, and my pharmacy. I have been informed and understand that Magnolia Health, PLLC providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to Magnolia Health, PLLC providers to see this health information.

IMMUNIZATION REGISTRY:

I understand that Magnolia Health, PLLC (Magnolia Health Primary Care) participates in the North Carolina Department of Health & Human Services statewide immunization registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine-preventable diseases. The registry complies with federal health information privacy laws. I do hereby grant permission for Magnolia Health, PLLC, to send or fax childhood immunization records to schools upon request.

_____ _____

Signature of Patient or Parent/Legal Guardian/Authorized *Relationship to Patient (If Applicable)*

_____ _____

Witness Name & Signature *Date & Time Signed*