Patient Information (Please fill form out completely) Today's Date: _____/_____/_____

_____ _____

Last Name First Name MI Date of Birth

Male/Female _____@_____.com

Email

Marital Status ____ Single ____ Married ____ Divorced ____ Widowed Language ___ English ___ Spanish ___ Other

Race ___ White-Non-Hispanic ___ Black Non-Hispanic ___ Hispanic ___ American Indian ___ Asian/Pacific ___ Other

_____

Patient's home address City State Zip

(___)_____(___)_____(___)_____

Home Phone Cell Phone Alt. number

_____(____)_____

Employer _____ Employer Phone _____

Is this a worker's comp claim? Yes/No Is this related to an automobile accident? Yes/No

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Primary Insurance_____ Secondary_____

Relationship to Patient ___ SELF (If self, skip to emergency info) ___SPOUSE ___ PARENT ___ OTHER

- Please give cards to receptionists to copy

_____ ____/_____/_____/_____-_____-_____

Policy Holders Last Name First MI DOB Social Security Number

_____

Mailing address if different City State Zip

Emergency Contact/Next of Kin

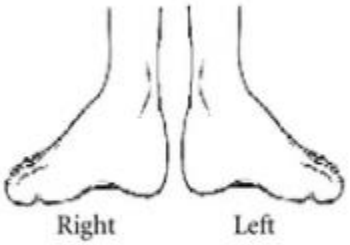
Name	Relationship	Home Number	Cell Number

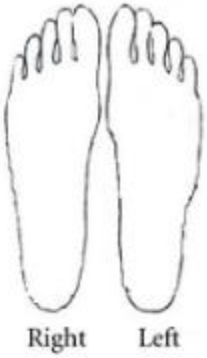
1. What brings you to our office? Please describe the symptoms you are having:

   _____

   _____

2. Please indicate where your pain/issues are located:





Name: _____ Date of Birth: _____

Physician Referral Information

_____

Primary Care Doctor | Referring Physician (if different)

_____

City | Office Phone | Date last seen by primary doctor

PAST MEDICAL HISTORY

1. Please check if you have any of the following conditions:

__ No medical history	__ Bronchitis	__ Gout	__ Pneumonia
__ Acid Reflux	__ Cancer	__ Heart Attack	__ Seizures
__Anemia	__ Cataract/Glaucoma	__Hepatitis	__ Stroke
__ Anxiety/Depression	__ Diabetes	__ High Blood Pressure	__ Thyroid disease
__ Arthritis	__ Emphysema	__ Poor circulation	___ Tuberculosis
__ Blood clot (DVT)	__ Other medical problems, explain: _____		

_____

If you are living with Diabetes, what was your last Hemglobin A1C? _____ Date _____

- Has anyone in your family gotten an amputation due to diabetes? Yes No

2. Please list any operations, surgeries or hospitalizations:

_____

3. Social History

Does the patient smoke: ___ No ___ Yes If yes, how often? _____

Previous smoker: ___ No ___ Yes

Do you drink: ___ Never ___ Moderate (sometimes) ___ Heavy

Do you exercise: ___ No ___ Yes If yes, is it more than 3 times a week? ____ No ____ Yes

Medical History

Please list the current medications and how often you take them

Name of medication	Strength	How often

May list additional medication below

4. Pharmacy

Local_____ City_____

Mail order_____

Medical allergies:

__Aspirin __Adhesive tape __Codeine __Iodine __Latex __ Local anesthetic __Penicillin

__Sulfa Other_____ No Medical allergies _____

Is the patient taking a blood thinner? ____ Yes _____ No

Financial and Payment Policy

We would like to say **"thank you"** for choosing Magnolia Foot Care for your podiatric needs! Our physician and staff are very concerned about the cost of your health care and want to inform you of our policies regarding payment.

1. In order to bill your insurance company for your health care costs, **it is extremely important that we obtain complete information about your primary and/or supplemental insurance companies, including phone numbers, addresses and a copy of your insurance card.** If this information is not provided, you will be required to pay any charges in full at the time of service. We will also use the information you provide to help you with your insurance company's pre-authorization process, if required.

a. **If your insurance changes at any time we require a 48 hour notice** to verify benefits and complete required treatment precertification or authorizations when necessary. Failure to notify our Patient Accounts Department within this timeframe may result in a delay in receiving services or require that your visit be rescheduled.

b. To maintain accuracy in filing your claims **a copy of our picture ID and your insurance card(s) is required at** your first visit, any time your coverage changes and yearly.

2. At the time of your first appointment in our office you will meet and discuss your insurance plan with a representative from our Patient Accounts Department. Whenever possible, Magnolia Foot Care will assist you with your understanding of your insurance policy details. However, Magnolia Foot Care **cannot guarantee confirmation of your coverage or benefits by your insurance company.**

3. **Payment in full is expected** when services are rendered unless other specific arrangements are made in advance with our Patient Accounts Department. For your convenience **we accept Visa, MasterCard, American Express and Discover as well as personal checks, money orders and cash.**

Fees - Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of the care rendered and the skill and expertise required for your care. We have ensured that our fees are comparable to the other physicians providing the same quality and level of care. Many private insurance companies, **in an effort to discount physician fees, restrict payment indicating that fees are over their "Usual and Customary" fees for this area.**

Copays/Coinsurance/Deductibles – Our Financial and Payment policy requires **payment for your deductible and/or co-insurance at the time of service for office visits and procedures.** We will file a

claim for services on your behalf. In the event there are any additional balances, which may be your responsibility, **you will receive a statement that is to be paid before the end of the month.**

Medicare & Medicare Advantage – We are a participating provider with Medicare & Medicare Advantage programs. We will submit your claim to Medicare who will process any payment due directly to us. **You are responsible for your deductible and co-pays at the time of service.** If you have a Medigap (Supplemental Insurance) policy Medicare will automatically submit your secondary claims for you.

Referrals – If your insurance carrier requires a referral or authorization for your visit, **it is your** responsibility to make sure that our office receives current valid authorization. If you do not have a valid referral or authorization at the time of service, you may be sent back to your Primary Care Physician to obtain authorization prior to being treated or full payment will be expected at the time of service. **Please remember that it is your responsibility to make sure we are on your plan's provider listing.** We appreciated your understanding of the ever-changing requirements of managed care plans and our position to adhere to their policies.

Secondary Insurance – As a courtesy to you, our Patient Accounts Department will file your claim if we have valid information on file.

NON-Contracted Insurance (Out of Network) - If you have an insurance plan that we do not participate with, you may have **out of network benefits. These benefits typically have a higher co-pay, coinsurance and/or deductible out of pocket cost.** If you choose to have services rendered at Magnolia Foot Care these amounts will be due at the time of service is rendered. **You will be considered a self-pay, uninsured patient if you do NOT have out of network benefits.**

Uninsured/Self-Pay – **We offer a discount to all of our self-pay patients. Payment is expected at your first visit.** All of ancillary, treatment and future care will be reviewed with you in order to make arrangements for payment.

Termination of Benefits – It is **your responsibility to contact us within 48 hours of any appointment, if you have any change in insurance coverage**, including COBRA benefits (see COBRA section below).

COBRA – It is our financial and payment policy that **we verify current coverage within 48 hours of your appointment for all patients who receive COBRA benefits.** If current **coverage can NOT be verified, ALL treatment will be scheduled at an Outpatient Infusion Center.** It is your responsibility to contact us immediately of any insurance change.

Returned Checks – **Returned checks are subject to a $30 service charge.** If multiple returned checks are received, we reserve the right to refuse further checks from you and request that all payments be received in cash, money order, cashier's check or credit card.

Non-Payment – If any account becomes delinquent, Magnolia Foot Care, reserves the right to have a collection agency take over the account. **If any account is placed with a collection agency, the patient will be responsible for all costs of collection and any legal proceedings.** Timely payment will prevent consequences to your credit rating.

Medical Records – We charge a fee for the release of medical records. All balances are to be paid in full prior to the release of medical records. There is also a charge for HMLA Forms.

We will work with patients in any way we can to ensure that their medical care is the finest available and that this care does not become a financial burden. If you have any questions about our financial policy or your insurance reimbursement, please contact our Patient Accounts Department.

Please sign and date this form, acknowledge that you have read and understand our financial policy.

_____ _____

Signature of Patient **Date**

Acknowledgement of Notice of Privacy Practice

Effective April 2020, our Notice of Privacy Practices provided information about how we may use and disclose protected health information about you. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you acknowledge that **Magnolia Foot Care, LLC** has provided you with our Notice of Privacy Practice and answered any questions you may have.

_____ _____

Patient Signature Date

_____ _____

Parent or Guardian Signature Date

Consent to receive Text / Emails

By signing below, you consent to receive text messages from Magnolia Foot Care at the phone number &/or email provided on page 1. We are committed to protecting your privacy. We will never sell, rent, or give away your personal information to any third party. You may withdraw your consent at any time by replying with "STOP" to any text message, email or by contacting us directly.

- Signature: _____
- Date: _____

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Magnolia Foot Care, LLC. When you schedule an appointment with Magnolia Foot Care, LLC 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, and 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 May 23, 2022 any established patient who fails to show or cancels/reschedules 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/reschedules an appointment with no 24-hour notice a **second time** will be charged another **$25.00 fee.**
- If a **third** No Show or cancellation/reschedule with no 24-hour notice should occur, the patient may be **dismissed** from Magnolia Foot Care, LLC.
- Any new patient who fails to show for their initial visit will not 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.**
- 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 / Dr. Floyd, who may be able to waive the No Show fee. You can call or email us to cancel your appointment 24 hours a day 7 days a week. If you leave a message, we will check time to make sure that you accommodated the 24-hour notice.

- Email: contact@magnoliafootclinic.com
- 352-432-5790 – Main Office

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

_____ _____ _____

Signature (Patient/Parent/Legal Guardian) Relationship to Patient Date