



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

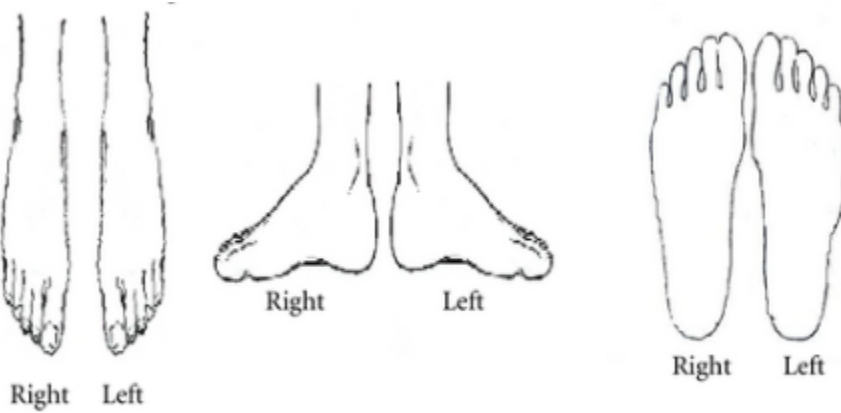
Emergency Contact/Next of Kin

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:



Physician Referral Information

Primary Care Doctor	Referring Physician (if different)
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City	Office Phone	Date last seen by primary doctor
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Past Medical History

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

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> No medical history | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cataract/Glaucoma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Tuberculosis |



Blood clot (DVT) Other medical problems, explain: _____

If you are living with Diabetes, what was your last Hemoglobin 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

Please list the current medications and how often you take them

Name of medication	Strength	How often

May list additional medication on separate sheet

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 most 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



appreciate 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 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 to acknowledge that you have read and understand our financial policy.

Signature of Patient

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



Privacy Policy: Effective Date: April 2002

1. Introduction

This privacy policy outlines how Magnolia Foot Care, LLC (referred to as "we," "us," or "our") collects, uses, and protects your personal health information.

2. Information We Collect

We may collect the following types of information:

- **Personal Identification Information:** Name, address, phone number, email, date of birth.
- **Health Information:** Medical history, treatment records, medications, allergies.
- **Payment Information:** Insurance details, billing information.

3. How We Use Your Information

We use your information for:

- Providing medical care and treatment.
- Billing and payment processing.
- Communicating with you about appointments and health information.
- Improving our services and patient care.

4. Disclosure of Your Information

We may share your information with:

- Healthcare providers involved in your care.
- Insurance companies for billing and reimbursement.
- Legal authorities if required by law.

5. Patient Rights

You have the right to:

- Access and obtain a copy of your medical records.
- Request corrections to your information.
- Restrict certain uses of your information.
- Receive a copy of this privacy policy

6. Security of Your Information

We implement a variety of security measures to protect your personal information, including:

- Secure electronic systems and encryption.
- Restricted access to authorized personnel only.
- Regular audits of our privacy practices.

7. Changes to This Policy

We may update this policy periodically. Any changes will be posted on our website, and you will be notified if there are significant changes.

8. Contact Us

If you have any questions or concerns about this privacy policy, please contact us at 352-432-5790.

Acknowledgement of Notice of Privacy Practices



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

Patient Signature

Date

Opt-In Permission to Send Text Messages Form

Magnolia Foot Care would like to contact you via text messages on your personal cell phone to provide appointment reminders and important updates.

Please initial below if you wish to be contacted via text message or prefer not to be contacted via text message.

_____ (Initial) Yes, I want Magnolia Foot Care to send text message to my cell phone number as listed below.

_____ (Initial) No thank you. I prefer to be contacted in person via regular telephone call.

Contact Information

Full Name: _____

Cell Phone Number: _____ (if Yes)

You may withdraw (Opt-Out) your consent at any time by replying STOP to any text message or by contacting us directly at 352-432-5790.

Signature: _____ Date: _____