Patient Information
(Please fill out the form completely)

Personal Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Email: _____@_____.com

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Language: ☐ English ☐ Spanish ☐ Other: _____
Race: ☐ White (Non-Hispanic) ☐ Black (Non-Hispanic) ☐ Hispanic ☐ American Indian
☐ Asian/Pacific ☐ Other

Contact Information

Home Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers
Home: *(___)*_____ *Cell: (___)*_____ Alt. Phone: (___) _____

Employer Information
Employer Name: _____
Employer Phone: (___) _____

Insurance Information *Please provide insurance cards to the receptionist for a copy*

Primary Insurance Co: _____
Policy Number: _____

Secondary Insurance Co: _____

Policy Number: _____

Policy Holder Information
Policy Holder's Last Name: _____ First Name: _____
MI: _____ Date of Birth: _____

Mailing Address (If different)
Street Address: _____
City: _____ State: _____ Zip: _____

Emergency Contact Information
Emergency Contact Name: _____
Relationship: _____
Phone Number: (___) _____

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

Reason for Visit

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

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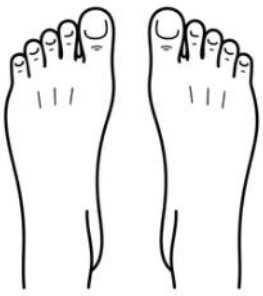
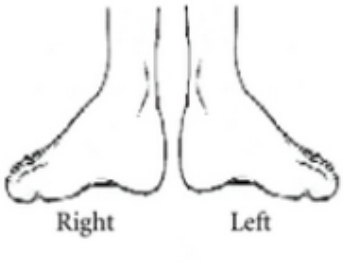
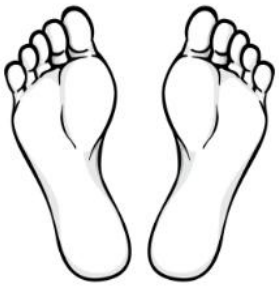
2. **Please indicate where your pain/issues are located:**



Left Right





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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

☐ Arthritis	☐ Cancer	☐ Gout	☐ Poor circulation
☐ Acid Reflux	☐ Cataract	☐ Heart Attack	☐ Seizures
☐ Anemia	☐ Depression	☐ Hepatitis	☐ Stroke
☐ Anxiety	☐ Diabetes	☐ High Blood Pressure	☐ Thyroid disease
☐ Blood clot (DVT)	☐ Emphysema	☐ Parkinsons	☐ Tuberculosis
☐ Bronchitis	☐ Glaucoma	☐ Pneumonia	

   ☐ Other medical problems (explain): _____

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2. **If you are living with Diabetes, what was your last Hemoglobin A1C?**
   A1C: _____ **Date:** _____

   Has anyone in your family had an amputation due to diabetes?
   ☐ Yes ☐ No

3. **Please list any operations, surgeries, or hospitalizations:**

Social History

- **Does the patient smoke?**
  ☐ No ☐ Yes (If yes, how often?) _____
- **Previous smoker?**
  ☐ No ☐ Yes
- **Do you drink alcohol?**
  ☐ Never ☐ Moderate (sometimes) ☐ Heavy

- **Do you exercise?**
  ☐ No ☐ Yes (If yes, is it more than 3 times a week?)
  ☐ No ☐ Yes

Current Medications

Please list the current medications and how often you take them:

Name of Medication	Strength	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list additional medications on a separate sheet if necessary.

Pharmacy Information

Local Pharmacy: _____
Address & City: _____

Mail Order Pharmacy: _____

Medical Allergies

Please check if you are allergic to any of the following:
☐ Aspirin ☐ Adhesive tape ☐ Codeine ☐ Iodine ☐ Latex ☐ Local anesthetic
☐ Penicillin ☐ Sulfa ☐ Other: _____
☐ No known allergies

Blood Thinners

Is the patient taking a blood thinner?
☐ Yes ☐ No

Financial and Payment Policy

Fees and Payment Methods:

Magnolia Foot Care aims to keep fees reasonable for the exceptional quality of care provided.

- Payment is accepted via Visa, MasterCard, American Express, Discover, personal checks, money orders, Apple Pay, and cash.
- Returned checks incur a $30 service charge, and repeated returned checks may result in the requirement to pay via cash, money order, cashier's check, or credit card.

Non-Payment:

- Accounts that become delinquent may be sent to a collection agency, with the patient responsible for all associated costs and legal fees.
- Medical records will not be released until all balances are paid in full.

Insurance:

- Patients should verify coverage with their insurance company before visiting.
- Payment for copays and coinsurance is due at the time of service.
- It is the patient's responsibility to ensure that required referrals or authorizations are in place.
- Magnolia Foot Care will file secondary insurance claims, but it is the patient's responsibility to provide complete insurance information.
- Patients must notify the office of any insurance changes within 48 hours.

Uninsured or Self-Pay Patients:

- Uninsured / Self-Pay patients will be quoted a set amount for services, which must be paid in full at the time of service unless other arrangements are made.
- For out-of-network insurance plans, higher out-of-pocket costs may apply, and payment is due at the time of service.

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

_____ _____

Signature of Patient Date

Appointment Cancellation/No Show Policy:

Patients are encouraged to notify the office as soon as possible if they are unable to attend their scheduled appointment. This policy ensures the efficient use of time and resources at our office.

1. 24-Hour Notice:
    - Patients must contact the office at least 24 hours in advance to cancel or reschedule an appointment. This allows the office to accommodate other patients who may be waiting.

2. No Show Fees:
    - First & Second No Show or Late Cancellation: $25 fee if the patient fails to show or cancels/reschedules without providing at least 24 hours' notice.
    - Third No Show or Late Cancellation: The patient may be dismissed from Magnolia Foot Care.

3. New Patients:
    - If a new patient misses their initial appointment without notice, they will not be rescheduled.

4. Fee Responsibility:
    - The fee is the responsibility of the patient, not the insurance company, and must be paid at the time of the patient's next office visit.

5. Reminder Calls:
    - Reminder calls may be made when time permits, but the cancellation/no-show policy will still apply if a reminder is not received.

6. Emergency Situations:
    - In cases of extenuating circumstances (e.g., emergencies), the No Show fee may be waived at the discretion of Dr. Floyd.

7. Contact Information:
    - To cancel an appointment, you can call or email the office anytime:
        - Email: contact@magnoliafootclinic.com
        - Phone: 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

This policy describes how your personal health information is collected, used, and safeguarded by **Magnolia Foot Care, LLC**.

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1. Information We Collect:

- **Personal Identification Information**: Includes name, address, phone number, email, and date of birth.
- **Health Information**: Includes medical history, treatment records, medications, and allergies.
- **Payment Information**: Includes insurance details and billing information.

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2. How We Use Your Information:

We use your information for the following purposes:

- **Providing medical care and treatment.**
- **Processing billing and payments.**
- **Communicating with you about appointments and health updates.**
- **Improving patient care and services.**

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3. Disclosure of Your Information:

Your information may be shared with:

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

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4. 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.

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5. Security of Your Information:

Magnolia Foot Care uses various security measures to protect your personal information, including:

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

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6. Changes to This Policy:

The privacy policy may be updated periodically. Any significant changes will be posted on the website, and you will be notified accordingly.

This policy is designed to ensure transparency and provide patients with clear rights regarding their health information. If you have any questions or concerns about this privacy policy, you can contact Magnolia Foot Care 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: _____

Authorization for Release of Medical Records

I, the undersigned, hereby authorize **Magnolia Foot Care, LLC** and its staff to release any necessary medical records, information, or documents as required for the purposes of my medical care, treatment, and billing. This may include, but is not limited to, communications with other healthcare providers, insurance companies, and medical institutions, as well as sharing information with my referring physician, primary care doctor, or specialists involved in my care.

I understand that the information to be disclosed may include sensitive medical records, including but not limited to my diagnosis, treatment, medications, and other health-related information. I acknowledge that I have the right to request copies of my medical records and to withdraw this consent at any time by providing written notice to **Magnolia Foot Care, LLC**.

This release is valid for the duration of my treatment and for the purpose of providing necessary information for my care. I understand that I am not required to sign this release as a condition of receiving treatment, and that my refusal to sign will not affect the quality of care I receive.

By signing below, I confirm that I understand and consent to the release of my medical records as described.

Patient Name (Printed): _____
Patient Signature: _____
Date: _____

Opt-In Permission to Send (Text) SMS (Short Message Service) Messages

Magnolia Foot Care would like to contact you via text messages on your personal cell phone to provide appointment reminders and important general office updates. Typically we will send 1-2 messages per month (e.g., appointment reminders or routine follow-ups) depending on the frequency of your visits.

Please initial and sign 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 messages to my cell phone number as listed below.**

Mobile Number: _____

By providing your mobile phone number, you consent to receive SMS messages from Magnolia Foot Care, LLC for purposes including but not limited to appointment reminders and general notifications.

- I consent to receive SMS messages related to my medical care.
- I understand that I can opt-out of SMS communications at any time by replying “STOP” to any message.
- I understand that my mobile number will only be used for these communications and will not be shared with third parties, except as required by law.

HELP Information: For assistance, please contact our office at 352-432-5790. We’re here to help!

I have read and understand the SMS communication policy and agree to receive SMS messages.

Signature: _____

Date: _____

Opt-Out Instructions: 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**.

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