MAGNOLIA

medical & aesthetics

Patient Registration Information: (Please print clearly)

All bold areas must be completed by adult (18+) or legal guardian (for minors)

Legal Name:_____
First Last M.I.

Nickname? _____ **Date of Birth:** _____ **Age:** _____ **Gender:** M F

Primary Address:_____ **City:**_____ **State:** ____ **Zip:**_____

Primary Phone :(___) _____ Other: (___)_____ **Under 18?** Yes No

Occupation:_____ Social Security Number: _____

Email Address* (appointment confirmation, billing correspondence, advertising): _____@_____. ____
*may opt out of advertising emails via "unsubscribe" upon receipt of email.

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

EMERGENCY CONTACT- Name: _____ **Primary Phone:** _____

Relationship to patient: _____

Patient Doctor (Internist, Family Practitioner, Pediatrician): _____

Address:_____ **Phone:** (___) _____

Pharmacy Name & Phone Number:_____

How did you hear about us/Referred by? _____

FOR MINORS - Parent or Guardian Information

Name: _____ **Date of Birth:** _____ **SSN:** _____

Employer: _____ **Phone:** (___) _____

Employer's Address: _____

REASON FOR VISIT (*CIRCLE ONE*):

MEDICAL / COSMETIC

MEDICAL INSURANCE INFORMATION:

Name of Insurance Company: _____ **Type of plan:** _____

Member ID #:_____ **Group #:**_____ **RX Bin:** _____

Policy Holder's Name:_____ **Date of Birth:** _____

Relationship to Patient (circle one): Parent/Spouse/Dependent **SSN:** ___-___-___

Employer:_____ **Phone:** (___) _____

Medical Information

I. Medical/Surgical History:

Do you have now or have you ever had:

	Yes	No
Thyroid Disease		
High Blood Pressure		
Diabetes/High Blood Sugar		
Asthma		
Tuberculosis		
Hay fever/Seasonal Allergies		
Seizures		
Stroke/Mini-Stroke		
Heart Attack/Angina		
Pacemaker		
Heart Murmur/Palpitations		
Kidney/Bladder Problems		
Prostate Problems		
Glaucoma		
Hepatitis/Liver Disease		
Recurrent Yeast Infections		
Bowel Disease/Colitis/Crohn's		
Frequent/Severe Headaches/Migraines		
Cancer (other than skin)		
Radiation		
Artificial Joint Heart Valve		
Past Surgery		
Other		

If YES to any above, please explain:

II. Current Health:

	Yes	No
Do you smoke?		
How much per day?		
Do you drink alcohol?		
How much?		
Do you use drugs?		
How much?		

III. Medications

List all medications you are taking, including any over-the-counter herbals or vitamins:

IV. Dermatologic History:

Do you have now or have you ever had

	Yes	No
Keloids/Abnormal Scarring		
Poor Wound Healing		
Skin Pigmentation Problems		
Reaction To Local Anesthetics		
Cold Sores/Herpes Infections		
Eczema		
Psoriasis		
Abnormal ("Dysplastic") Moles		
Precancerous Spots		
Skin Cancer – Melanoma		
Skin Cancer – Basal Cell		
Skin Cancer – Squamous Cell		
Abnormal Cold Sensitivity		
Abnormal Sun Sensitivity		
Abnormal Sun Sensitivity		
Cosmetic Surgery		

If 'Yes' to any above, please explain:

V. Allergies:

Are you sensitive / allergic to any oral medications? Please List:

VI. Family History

Do you have a family history of:

	Yes	No
Allergies/Asthma		
Skin Cancer – Melanoma		
Abnormal ("Dysplastic") Moles		
Skin Cancer – Basal/Squamous Cell		
Other Skin Disorder		

VII. Females

	Yes	No
Excess Facial/Body Hair		
Irregular Menstrual Periods		
How many pregnancies?		
How many miscarriages/abortions?		
Are you pregnant or nursing?		
Names/ages of your children:		

NOTICE TO PATIENT: THIS PAGE MUST BE FULLY COMPLETED/SIGNED

Physician-Patient Arbitration Agreement (PPAA):

I acknowledge that I have seen and read the PPAA:_____ *Copy available upon request.*
Initials

I acknowledge that I understand and agree to have any issue of medical malpractice decided by natural arbitration and understand my patient rights under the Physician-Patient Arbitration Agreement: _____
Initials

_____**Date:** ___/___/___ **Physician/Authorized Office Personnel:** _____
Patient/Legal Guardian Signature

Authorization to Contact Patient and Record of Disclosures (HIPAA):

The **HIPAA** privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (**check all that apply**):

___Okay to give detailed information via Voicemail, Email or Text
___Leave a message with office call back number only via Voicemail, Email or Text

___Other:_____

I authorize the release of protected health information to the individual(s) listed below:

Name:_____Phone: (___) _____ Relationship: _____

Name:_____Phone: (___) _____ Relationship: _____

I understand that I may revoke this authorization at any time by submitting a written request:

_____ _____
Patient/Guardian Signature **Printed Name of Patient/Guardian** **Date** ___/_____/____

I acknowledge that I have seen the Notice of Privacy Practices: _____ *Copy available upon request.*
Initial

I acknowledge that I have read and understand the Office Policies: _____ *Copy available upon request.*
Initial

Assignment of Rights & Benefits

Patient's Name (or responsible party for a minor)

I herby assign all rights and benefits under my contract with my insurance company to Magnolia Medical & Aesthetics and/or Providers for the purposes of determining the details of the benefits of my policy and obtaining payment for services given.

The assignment further permits Magnolia Medical & Aesthetics and/or Providers to obtain from my insurance all information necessary, for the determination of benefits allowed under the contract and permits the direct disclosure to Magnolia Medical & Aesthetics of all information including benefits provided, limits and exclusions of benefits and reasons for denial of benefits or reduction in charges for services rendered.

The assignment shall allow Magnolia Medical & Aesthetics and/or Providers to take actions necessary to obtain the benefits I have, in good faith, been promised by my insurance. All benefits are to be paid directly to Magnolia Medical & Aesthetics and/or Providers.

A photocopy of this assignment shall be considered as effective and valid as the original.

I further authorize Magnolia Medical & Aesthetics and/or Providers to initiate a complaint to the Insurance Commissioner's office for any reason on my behalf.

I understand that my insurance carrier may disallow certain diagnoses or services as medically uncovered, medically unnecessary or cosmetic. I agree to be responsible for payment of all such services rendered to my dependents or me.

I also understand that my insurance policy is a contract between my insurance company and myself. If my insurance company does not pay a claim within 30 days after it is received, I agree to remit payment to Magnolia Medical & Aesthetics and/or Providers within 2 weeks of receiving the bill. I agree to contact my insurance company regarding this settlement. Magnolia Medical & Aesthetics and staff will assist me in processing my claim; however, I am ultimately responsible for payment of services rendered.

I agree that if my insurance carrier issues a check in my name for reimbursement for services rendered by either the physician and/or facility, I will within five days of receipt of this check make payment in the amount of said check to the physician or facility.

A $37.50 fee will be charged for each insufficient funds check returned.

This is a direct assignment of my rights and benefits under this policy.

Printed Name of Patient _____

Printed name: (if other than patient) _____

Patient/Guardian Signature _____

Date _____

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Prescription Refill Policy

- It is the patient's responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three business days so please be courteous and do not wait to call.
- Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers. If you are new to the area, you must have medical records sent to our office if you are requesting medication refills that we did not prescribe for you.
- It is important to keep your scheduled appointment to ensure that you receive timely refills. We do require our patients taking prescription medication to be re-evaluated on a regular basis. Repeated no shows or cancellations will result in a denial of refills. All prescriptions require follow up appointments per the provider's recommendations and/or medications that are at a stable dose for 6mths will require annual visits at a minimum. All medication refills must have an appropriate follow-up visit, (i.e. acne office visit for acne medication refill, primary care visit for blood pressure medication refill, weight management visit for weight management medications). Most prescriptions expire after 1 year; if your prescription is expired, a re-evaluation is required.
- Please bring all your prescription bottles with you to your appointment. This is important to allow our office to verify which medications you are taking and to confirm you are taking the correct medications and the correct doses.
- Antibiotics will not be called in without a visit. If a patient is sick enough to need antibiotics then they are sick enough to need a provider's evaluation.
- New symptoms or events require a clinic appointment. Your provider will not diagnose or treat over the phone.
- If you have any questions regarding medications please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed please contact us immediately.
- Your insurance may require a prior authorization for your prescription medication. Depending on your insurance this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.

____ (initials) I have received and read a copy of this medication policy

Medication Policy Signature Page

_____ Date_____

Patient Signature

_____ Date_____

Witness Signature