

New Patient Information

Name: _____ (As it appears on insurance card)

DOB: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (Cell) _____ (Home) _____

Email: _____

Pharmacy name: _____

Insurance Information
(Please give front desk a copy of card)

Ins. Carrier: _____ Policy #: _____

Group# _____ Subscriber: _____

What brings you to MMG today? _____

Have you been treated for this condition before?

Yes () No ()

If so, when? _____ Physician _____

Is this the result of an accident/ injury? Yes() No()

Do you have access to recent X-rays (within 1year) _____?

Whom may we thank for referring you to our office? _____

**Magnolia Medical Group
Medical Initial form**

Patient Name: _____ **Date:** _____

DOB: _____ **Preferred Pharmacy:** _____

Weight: _____ **Height:** _____

Who is your primary care physician? _____

Have you had labs within the past year? _____

If so, When: _____ **Do you have any allergies?** _____

Medical History:

Please list any medical conditions
you are currently being treated for

Current Medications:

Please list all medications and supplements
you are currently taking with the dosage and
frequency

What are you seeing our medical staff for today?

Have you been treated for this condition previously? If so, when?

Please only complete if you are being seen for our medical weight-loss program-

-What programs you have tried in the past _____

-What do you struggle with the most concerning your weight? _____

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA
REPRESENTATIVE AND BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Magnolia Medical Group (Justin Lance, D.C., Haley Lance, D.C., Gregory Daniel Bennett, M.D., Chelsea Lewis, NP-C)** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been or will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____.
(SEAL)

X _____
(patient signature)

X _____ (SEAL)
(signature of Guardian if applicable)

X _____
(please print patient name)

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative

Date

Printed Name of Patient of Personal Representative

Date



PATIENT ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM FOR MAGNOLIA MEDICAL GROUP

Please list any other parties who may obtain access to your health information:

(This includes any medical records, appointment times/details, financial information, etc.)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST MY MEDICAL RECORDS BE SENT TO ANOTHER ATTENDING DOCTOR/FACILITY IN THE FUTURE.

Please *print* patient's name

Please *sign* patient's name

Legal Guardian

Date

Ownership Notice to Patients

Because of concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has an ownership interest the State of Georgia passes the Patient Self Referral Act of 1993 (GA Code, Title 43, Chapter 1B)

Under this law, I must disclose my ownership in this facility and other facilities in which I have an ownership interest. This disclosure is intended to help you make a fully informed decision about your health care. You have the right to obtain healthcare items or services at a location or from a provider or supplier of your choice, including the facility in which I am owner. I assure you that you will not be treated differently if you do not choose the facility listed below in which I have an ownership interest.

Dr. Justin Lance and Dr. Haley Lance

has an ownership interest in:

**Magnolia Medical Group, LLC
946 Harmony Road
Eatonton, GA 31024**

**Sports Spine Wellness (doing business as Magnolia Medical Group)
946 Harmony Road
Eatonton, GA 31024**

SIGNATURE: _____

DATE: _____

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operation of this office. A copy of our notice is attached, and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the provider with respect to my protected health information. I hereby give permission to Magnolia Medical Group (MMG) to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to MMG to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If MMG contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.
- I give permission to MMG to use my name on a welcome board, referral board and birthday board.
- I give permission to MMG to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give MMG permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my Protected Health Information during care. Should I need to speak with the doctor anytime in private, the doctor will provide a room for these conversations.
- By signing this form, you are giving MMG permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at MMG plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or acted in reliance to your situation.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of MMG. The written notice must contain the following information:

- Your name, social security number and date of birth
- A clear statement of your intent to revoke the AUTHORIZATION
- The date of your request; and your signature

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by MMG for its own use/disclosure of PHI. *(Minimum necessary standards apply)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, MMG will not refuse to provide treatment however, it will not be possible for MMG to file third party billing on my behalf, and I will be responsible for 1) payment in full at the time services are provided 2) scheduling my own appointments since MMG will be unable to contact me 3) all contact with MMG regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN: _____ DOB: _____

Patients name (please print): _____

Patients Signature: _____

Today's Date: _____

Name of Personal Representative (if patient is unable to sign or a minor)

Parent or Personal Representatives name (please print): _____

Signature: _____

Description of Representatives Authority to Act on Patients Behalf:

CANCELLATION AND MISSED APPOINTMENT POLICY

Our goal at Magnolia Medical Group is to provide quality, individualized medical and chiropractic care in a timely manner. Because of the increasing number of patients that either show up late or no-show for their scheduled appointment, we have been forced to initiate a new "late cancellation/ missed appointment policy" for our office. This policy applies to all patients, new and established.

LATE/NO-SHOW POLICY

A patient is considered "late" if he/she arrives 5 minutes after their appointment time. Our doctors allot 15-45 minutes for each patients' scheduled appointments (times varying between each patient) and we ask that you please be courteous and stay true to your designated time.

A patient who "no-shows" is a patient who misses an appointment without canceling within 24 hours. To cancel an appointment, patients may call and speak directly to our front desk staff or leave a voicemail if we are assisting other patients at the time of your call.

If a patient does not comply with our policies noted above, MMG respectfully reserves the right to bill \$50.00 to the patient's account or move the patient to a prepaid appointment status. If you are a new patient and "no-show", MMG reserves the right to charge the full new patient appointment fee of \$120.00 as explained on the phone when making the appointment. (Effective 6-17-23)

PREPAID STATUS APPOINTMENT

A patient that has 2 or more no-show appointments (within the calendar year) will be moved to a prepaid appointment status. This status will require your scheduled appointment to be prepaid prior to your arrival.

Signature _____ Date _____

Print _____