Magnolia
FAMILY PRACTICE
6336 Chapman Highway
Knoxville, TN 37920
(p) 865.888.0857 • (f) 865.099.5914
www.magnoliapractice.com

Consent for Procedure/Treatment

Patient:
DOB:
Address:

Date:
Patient ID.

I hereby authorize and direct _____ and assistants, as necessary to perform quality care, to perform the following procedure/treatment(s) on me:

- _____
- _____
- _____
- _____

The nature and purpose of the procedure/treatment, alternative methods of treatment, and potential risks and complications have been fully explained to me, including but not limited to:

- _____
- _____
- _____
- _____

I acknowledge that no guarantees have been made to me as to the outcome of the procedure(s) and/or treatment(s).

I grant this consent without duress, confusion, or pressure from my physician and/or staff, associates, or colleagues.

Patient/Representative Signature: _____

Date: _____

Witness Signature: _____

Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____
Phone: H) _____ Phone: W) _____
Address: _____ City/State/Zip: _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:
Facility Name: _____ Facility Phone: _____
Facility Address: _____ Facility Fax: _____
City, ST, Zip: _____

Dates and Type of information to disclose:
☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested: _____

The purpose of disclosure is:
☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: _____
Address: _____
City, State, Zip: _____ ☐ Please mail records.
Fax: _____ Fax: _____ ☐ Please mail records.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____
Signature of Patient / Parent / Guardian or Authorized Representative — Date
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____
Printed name of Authorized Representative — Relationship / Capacity to patient

_____
Address and telephone number of authorized representative

HIPAA ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information (PHI). PHI may originate in my medical record at Magnolia Family Practice (Practice), or may be received from outside health entities and filed in my medical record. I understand that this information can and will be used by the Practice to: (a) conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly, (b) obtain payment from third-party payers, or (c) conduct normal healthcare operations such as quality assessments.

I understand that the Practice may provide health information to assist in my care or for identification purposes in the event of a disaster unless I express my objection to such disclosures on this Acknowledgment.

☐ I agree

☐ I object

I have been informed of your Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my health information. I understand the Practice has the right to change its Notice of Privacy Practices from time to time and that I may obtain an up-to-date copy directly from the Practice or by contacting the Privacy Officer (865) 888-0857.

I understand that I may request, in writing, that the Practice restrict how my private information is used or disclosed to carry out my treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but, if you do agree, then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time except to the extent that I have taken action relying on this consent.

PATIENT CONSENT

☐The Practice *MAY NOT* discuss my healthcare and *MAY NOT* discuss and/or make financial arrangements with any immediate family member.

☐The Practice *MAY* discuss my healthcare and *MAY* discuss and/or make financial arrangements with any immediate family member.

☐The Practice *MAY NOT* discuss my healthcare, but *MAY* discuss and/or make financial arrangements with any immediate family member.

☐The Practice *MAY* discuss my healthcare, but *MAY NOT* discuss and/or make financial arrangements with any immediate family member.

The Practice may discuss my healthcare, and may discuss and/or make financial arrangements with only the individuals listed below:

1) Name: _____

Relationship: _____

2) Name: _____

Relationship: _____

3) Name: _____

Relationship: _____

4) Name: _____

Relationship: _____

ACKNOWLEDGMENT

I acknowledge that today I have received a copy of the Notice of Privacy Practices for Magnolia Family Practice.

_____
Patient Name (Print)

_____
Relationship to Patient (Optional)

_____
Signature

_____
Date

Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name:
First Name:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex: M
Pronouns: He/Him/His/She/Her/Hers/They/Them/Theirs
Date of Birth:
Social Security No.:
Patient email:
Required by government mandate [although you may refuse]:
Language:
Race:
Ethnicity:
Marital Status:

Guarantor Information (to whom statements are sent)

Name:
Address:
,
Relationship to patient: _____
Date of Birth:
Social Security No.:
Phone: ( ) _____ - _____

Emergency Contact Information

Name:
Relationship:
Phone:
Mobile Phone:( ) _____ - _____

Employer information

Employer:
Address:
Phone:

Other

Patient Referred by:

Primary Care Provider:

Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email / Spruce

Pharmacy Information:

Name:

Crossroads:

Phone:

Primary Insurance Information

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): M or F
Employer Name:
Patient's relationship to policy holder:

Secondary Insurance Information

Insurance Plan Name:
Last Name:
First Name.:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): M or F
Employer Name:
Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed_____ Date:_____

Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

- I have read and understand the HIPAA/Privacy Policy for MAGNOLIA FAMILY PRACTICE, LLC

Signed_____ Date:_____

- I hereby assign my insurance benefits to be paid directly to the healthcare provider

Signed_____ Date:_____

- I authorize MAGNOLIA FAMILY PRACTICE, LLC to release medical information required to process my claim

Signed_____ Date:_____

- I have read and understand the Financial Policy for MAGNOLIA FAMILY PRACTICE, LLC

Signed_____ Date:_____

- I authorize MAGNOLIA FAMILY PRACTICE, LLC to obtain/have access to my medication history

Signed_____ Date:_____

- I authorize my provider's office to contact me by mobile phone

Signed_____ Date:_____

6336 Chapman Highway
Knoxville TN 37920

Cancellation/No show fee Policy

We understand that you may sometimes need to reschedule appointments. When we make your appointment, please understand we are reserving time for you to see a provider. This courtesy makes it possible to give the best service here at Magnolia Family Practice. If you need to reschedule an appointment, please call the office as soon as possible or call at least 24 hours in advance.

If you have no showed for your appointment more than 1 time, you will be charged a $25 no show fee. After the 3d no show occurrence, you may be discharged from the practice. A no show is defined as failure to give 24 hours notice of cancellations.

We thank you for your trust in us here at Magnolia Family Practice.

Patient Signature Date

Magnolia
FAMILY PRACTICE

Patient Financial Policy

It is the policy of Magnolia Family Practice to provide you with information related to our billing processes and your financial responsibilities as our patient. This policy helps us in our mission to provide you with high quality medical care.

INSURANCE

We are in-network with most major health plans. As a courtesy to you, we will submit claims to your insurance plan and will provide reasonable assistance in getting those claims reimbursed. It is your responsibility to provide us with the correct information necessary to bill your insurance plan. If we do not have your current insurance information on file, then the balance will be transferred directly to you until the correct insurance information is obtained. You are ultimately responsible for the payment of your account.

Things to bring with you to each visit

1) Current insurance card(s)
2) Valid photo identification
3) Preferred method of payment for any co-pays due at the time of service

COPAYMENTS AND SELF-PAY

Co-payments are due at the time of check-in. Self-pay patients are asked to pay a minimum of $100.00 toward office visit fees.

OUTSTANDING PATIENT BALANCES

If your insurance plan has not paid the balance in full, you will receive a statement notifying you of the amount due. Patient balances must remain under $100.00 to be seen for an office visit. Unpaid accounts will be transferred to an outside collection agency upon delinquency.

As an alternative to mailing us your payment, we also offer other convenient options for paying your bill such as logging into your online patient portal or by contacting us directly at (865) 888-0857.

CONFIRMATION

I have read, understand and agree to the above Patient Financial Policy. I understand that charges for noncovered services, as well as copayments and deductibles, are my responsibility. I authorize my insurance benefits to be paid directly to Magnolia Family Practice on my behalf.

Patient Name: _____

Signature of Patient or Authorized Representative: _____

Date: _____

Magnolia
FAMILY PRACTICE

MEDICATION POLICY

Please be advised that if you are on any of the following medications or in a pain contract or receive pain management from another physician, you must continue to receive your medication from that physician. Our office WILL NOT routinely prescribe these medications. We want to be upfront with you regarding this so that we will be helping to eliminate any confusion. There may be other medications not listed below that may also be included in this policy. This will be at the discretion of our providers.

If you have any questions, please feel free to ask.

- Diazepam (Valium)
- Alprazolam (Xanax)
- Clonazepam(Klonipin)
- Lorazepam (Ativan)
- Codeine
- Fentanyl (Actiq, Abstral, Duragesic, Fentora)
- Hydrocodone (Hysingla, Zohyfro ER)
- Hydrocodone/Acetaminophen (Lorcet, Lortab, Norco, Vicodin)
- Hydromorphone(Dilaudid,Exalgo)
- Methadone(Dolophine,Methadose)
- Morphine (Kadian, MS Contin, Morphabond)
- Oxycodone (Oxaydo, Oxycontin, Percocet, Roxicet, Naloxone)
- Suboxone
- Methadone
- Ambien
- Lunesta
- Zaleplon
- Zolpidem
- Adderall
- Ritalin

Upon signing the acknowledgment of this policy, you are accepting this policy as set forth by this office.

SIGNATURE _____ PRINTED NAME _____

WITNESS _____ DATE _____