Patient Demographics

Name _____ Date Of Birth_____/_____/_____Sex_____
Parent/Guardian (if applicable) _____

Address_____

City_____State_____ Zip_____

Phone (C) _____(w)_____ (H)_____

E-Mail Address _____

Pharmacy Name: _____p: _____-_____-_____

Financial Responsibility

Name:_____Relationship to Patient: _____

Date of Birth: _____ SS#_____-_____-_____

Phone(H)_____ (C) _____ (w) _____

Primary Insurance Holder if Different from Above

Name_____Date of Birth_____/_____/_____

Phone Number_____-_____-_____ ss#_____-_____-_____

Primary Insurance:

Insurance Company _____

ID#_____ Group# _____

Emergency Contact Name_____

Relationship: _____

Phone Number:_____

General Consent for Care and Treatment Concern

To The Patient: You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

CONSENT FOR TREATMENT — I voluntarily consent to outpatient care and treatment performed by my physician and all other healthcare providers at Magnolia Family Medicine. I also consent to routine services, diagnostic procedures, medical treatment, and other health care testing and treatments deemed necessary by the health care providers treating me. I understand that if additional testing is recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

1. **CONSENT FOR TREATMENT OF A MINOR** — I hereby state that I have legal custody of the aforementioned minor and that I voluntarily grant my authorization and consent for the minor child to be treated for routine services, diagnostic procedures, medical treatment, and other health care testing and treatments deemed necessary by the health care providers treating said minor.

2. **RIGHT TO DISCUSS TREATMENT PLAN** — you have the right to discuss your treatment plan with your physician or other healthcare providers about the purpose, potential risks and benefits of any test or procedure ordered for you during and office visit. If you have any concerns regarding any test or treatment recommended by your physician or other healthcare provider, we encourage you to ask questions. We encourage to never assume any of your results are normal just because you did not hear back from the practice since a lot of times obtaining results are beyond our control considering your test timing and provider of your tests.

3. **PAYMENT AGREEMENT AND ASSIGNMENT** — except as prohibited by any agreement between my insurance company and Magnolia Family Medicine, or by federal or state law, I agree to be responsible for my copayment, deductibles or other charges for medical services not covered or paid by insurance or other third party payers. I authorize Magnolia Family Medicine to file any claims for payment of any portion of the patient bills and assign all rights and benefits to Magnolia Family Medicine. I further agree, subject to federal or state law, to pay all costs, attorney fees, expenses and interest in the event Magnolia Family Medicine takes action to collect because of my failure to pay in full all incurred charges.

4. ☐ I am the patient ☐ I am the parent/guardian of the patient ☐ Other relationship

By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, and that you consent to treatment at this office or any other satellite office under common ownership. The consent will remain in effect until I withdraw my consent in writing.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.Patient Name / Authorized Representative_____

Signature and Date _____ _____

Magnolia Family Medicine Clinic Policies

Our clinic has clarified these policies and procedures to answer the common questions regarding your care. Magnolia Family Medicine, your new medical home welcomes you. We are honored that you are trusting us with your health. Provide each patient with the best care possible within a friendly, professional atmosphere reminiscent of an era when doctors and their staff treated patients with compassion and dignity rather than as numbers or insurance statistics. Keeping you in good health is our primary concern. The patient guide that follows will familiarize you with our clinic and will answer questions you might have.

Testing Results: All testing results are usually posted on the patient portal but some are not. Patients are NOT to assume results are normal unless they see results on patient portal or are contacted by our office. From prior experiences patients donot like to be reminded to get diagnostic tests done and are annoyed or feel harassed when reminded to get them done thus we stopped reminding patients of past due testing. Thus, many instances we have no control of when and where patients get the testing done and we might not receive the results for many reasons. We encourage all our patients to let us know or call us back after getting tests done if they have not heard form our office within a reasonable period of time and NEVER assume we got normal results.

LAB :We use Clinical Pathology Laboratories but patients are free to use any laboratory they want. We encourage patients to sign up for online access to lab results directly through our patient portal. Our patient portal information system allows the patient to view the lab and imaging result. Abnormal lab results necessitate an appointment.

MEDICATION REFILLS: Medications are prescribed with specific refills based on treatment, please do not call our office for refills. It is the patient responsibility to schedule an appointment for additional refills.

ADD/ADHD MEDICATIONS: Stimulants (Ritalin, Adderall, Vyvanse, Etc.) are written on special state-controlled prescriptions or E-Rx. We require a minimum quarterly visit, including a urine drug screen

CONTROLLED SUBSTANCE SCHEDULE Ill: (Xanax, Ambien, Klonopin, Etc.) Are subjected to routine urine drug testing and office visits at least every' 3 months.

TESTOSTERONE THERAPY: Patients can receive testosterone injections at our clinic every 7-14 days. Such visits are billed to insurance companies as nurse visitsQuarterly visits with the provider and specific lab testing are required for any method of testosterone administration, whether topical or injected.

NARCOTIC MEDICATIONS: Schedule Il medications, including Vicodin, Norco, Oxycodone, Dilaudid among others, are not routinely prescribed by our clinic. Management of chronic pain will be referred to a certified pain specialist.

PRIOR AUTHORIZATION: Prior authorizations for unapproved medications may incur an additional fee.

PHONE MESSAGES: Phone messages will be returned within 24-48 hours

IMMUNIZATION OF CHILDREN: Our providers encourage parents to carefully consider CDC-recommended vaccinations, but he or she welcomes children, including ones not immunized. Our clinic does, however, request a signed waiver from a patient or guardian.

Thank you .

Patient/Guardian _____

Signature and Date _____

Patient Consent for Use Email Communications

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that although addressed to me, my staff and or colleagues would have access to this information.

Email address: _____

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above email policy. By signing below, you are agreeing that we may send medical related corresponded to you via email and that we may respond to your email to us via email.

Patient Signature:_____

Witness (optional) _____

Date:_____

MAGNOLIA FAMILY MEDICINE

DISCLOSURE OF PHYSICIAN OWNERSHIP INTEREST NOTICE TO PATIENTS

Please carefully review this notice. In order to allow you to make a fully-informed decision about your health care, the physicians of MAGNOLIA FAMILY MEDICINE (the "Practice") would like to inform you that at some point during the course of your treatment, the providers may refer you to alliance MRI to perform imaging studies. The Sleep Specialist of The Woodlands or MFM Pharmacy among other facilities.

The practice wishes to advise you that Dr Feras Elhajj has a direct ownership interest in:

Alliance MRI 1011 Medical Plaza Drive Suite 120 Spring Texas 77380

Sleep Specialist of The Woodlands 6912 Fm 1488 Suite B Magnolia TX 77354

MFM Pharmacy 6912 FM 1488 Magnolia TX 77354

All of the practice's physicians will make referrals to laboratories, diagnostic imaging centers or hospitals, based upon the best interest of a patient's health and any other factors that a patient would like his or her physicians to consider. Regardless of any ownership interest or compensation arrangement that a physician may have with a particular laboratory or other facility. You, as a patient, have the right to choose the provider of your healthcare services and the laboratories and other facilities where you receive services or treatment. For information about alternative laboratories, please ask your physicians affiliated with the practices or consult with your insurance company. If you have any questions concerning this notice, please feel free to ask your physicians or any member of our staff. We welcome you as a patient and value our relationship with you. By signing below, you acknowledge that you have read and fully understand this notice.

Signature of Patient Signature or Guardian _____

Print Name of Patient /Guardian and Date_____

ACKNOWLEDGEMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICE

This Joint notice of Privacy Practices applies to the privacy practices of the affiliated Entities and the

Entities Participating in the Organization Health Care Arrangement.

These Entities include: Westwood Primary Care PLLC **DBA: Magnolia Family Medicine**.

This form is used to document (a) an individual's acknowledgment of receipt of our Joint Notice of Privacy Practices.

Section A: Individual Name _____

Section B: Acknowledgement of Receipt of Joint Notice of Privacy Practices.

I Acknowledge that I have a Joint Notice of Privacy Practices from Westwood Primary Care PLLC.

Signature:_____ Date:_____

Include this Acknowledgement of Receipts in the individuals Medical Records Assignment of Benefits

I am the patient or legal Guardian

I acknowledge full responsibility for the payment of service received and agree to pay them in full at the time of service unless other arrangements have been made. I understand that insurance coverage is an arrangement between the insurance carrier and the patient. Westwood Primary Care PLLC will assist in billing my insurance company, but I am ultimately responsible for payment should my insurance fail to pay within a reasonable amount of time.

I authorize Westwood Primary Care PLLC to bill my insurance or third-party payer and receive payment directly from them for services rendered. I also authorize Westwood Primary Care PLLC to release information as required to my insurance or third-party payer (including my employer's worker compensation carrier), for the purpose of determining benefits. I understand that such records may include information regarding HIV/AIDS testing, substance abuse and /Or mental health issues. A photocopy of a faxed copy of this authorization shall be deemed as valid as the original.

My signature signifies acceptance of all terms in the Assignment of Benefits.

Signature of Patient/Parent/Guardian:_____

Date:_____

MAGNOLIA FAMILY MEDICINE/ WESTWOOD PRIMARY CARE PLLCFINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

ALL PAYMENT ARE EXPECTED AT THE TIME OF SERVICE: Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable copayments, coinsurance and deductible payments for participating insurance companies. We accept cash, personal checks (in-state only), Visa, MasterCard, Discover, And American Express. **THERE IS A SERVICE CHARGE FEE OF $30.00 FOR ALL RETURNED CHECKS**

LATE FEES: Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable copayments for payment prior to scheduling appointments. **THERE WILL BE A $30.00 MONTHLY LATE FEE CHARGE ON ANY BALANCE AFTER 30 DAYS**. All accounts more than 120 days past due will be transferred to a collections agency and you will be responsible for all agency fees and would adversely affect your credit rating with the credit bureaus.

INSURANCE: We bill participating insurance companies as a courtesy to you. You must present your most recent insurance card at the time of service. You are expected to pay your deductible/copayments at the time of service in full. **VERIFICATION OF BENEFITS IS NEVER A GUARANTEE OF PAYMENT; ALL CLAIMS ARE SUBJECTED TO THE TERMS OF YOUR PLAN AFTER FILING YOUR CLAIM.** If we have NOT received payment from your insurance company within 45 days from the date of service, you will be expected to pay the balance in full. You are responsible for all charges and all late fees. Your time of service receipt includes all information necessary for submitting claims to your insurance company. We do bill secondary insurance companies of applicable. **WE DO NOT FILE WORKERS COMPENSATION CLAIMS. WE DO NOT FILE CAR ACCIDENT/MOTORCYCLE ACCIDENT CLAIMS.**

MANAGED CARE: if you are enrolled on a managed care insurance plan (i.e. HMO) you must present your most recent insurance card with our primary care physicians name on it. If you do not have it at the time of service we will reschedule your appointment for a later date. Referrals will be given only after consultation with one of our doctors. You must receive a referral from our office before seeing specialist. No retroactive referrals will be given.

OUT OF NETWORK: We accept a variety of insurance plans, and due to the complexity of managed care contracts, we suggest patients to verify our doctors participation of **IN NETWORK STATUS** with their insurance company prior to making the appointment at MAGNOLIA FAMILY MEDICINE.

REFUNDS: Overpayments will be refunded upon written request within 30 days to the responsible party.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Broken appointments represent a cost to us, to you and other patients who could have been seen in the set aside for you. Cancellations are requested 24 hours prior to the appointment. **We reserve the right to charge for missed/late- cancelled appointments a minimum fee of $30**. Abuse of scheduled appointments may result in the discharge from the practice

I have read and understand **Magnolia Family Medicine FINANCIAL POLICY.** I agree to assign insurance benefits to Westwood Primary Care PLLC whenever necessary. I also agree that if it becomes necessary to forward my accounts to a collections agency I will be responsible for all collection fees.

Signature of patient/authorized representative _____ Date_____