Magnolia Pain Associates
Dr. Feghali
Board Certified Interventional Pain Management

Patients Name (First, MI, Last) Sex: F/M	DOB: MM/DD/YYY	Social Security #	Marital Status: S/M/D/W
Address:	City:	State:	Zip Code:
Email Address:	Referring Physician:	Home Phone #:	Cell Phone #:

Health Insurance:

Primary Insurance Name:	ID#	Group #
Secondary Insurance Name:	ID#	Group #

ASSIGNMENT & AUTHORIZATION FOR RELEASE OF INFROMATION FOR INSURANCE BENEFITS: I certify that if I, and/or my dependent(s), have insurance coverage, I shall assign to Magnolia Pain Associates and/or all authorized Medicare and other insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized the use of my signature or all insurance submissions. I appoint Magnolia Pain Associates to act as my authorized representative in requesting an appeal from my insurance plan regarding services or denial of payment. Magnolia Pain Associates and its affiliates/agents may use my health care information and may disclose such information to the health care insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize any holder or medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services. I understand that this authorization may include release of your Protected Health Information pursuant to 45 C.F.R s 164.520. I intend this consent to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment. Unless I request to the contrary, in writing, I will receive appointment reminders on my home or cell telephone answering system and/or other information regarding my treatment or invoices by mail to my home address. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due. The duration of this authorization is indefinite and continues until revoked in writing.

(Patient Initials) _____

I hereby certify that the reason for my visit is neither an injury/illness due to a motor vehicle accident nor is related to current/potential litigation. Furthermore, I certify that I have not met with/retained a person injury lawyer in the regard.

Patient's Signature: _____ Date: _____

MEDICAL HISTORY

Please circle all that apply, do you currently or have suffered from:

Dizziness Backaches Heart Trouble Diabetes Arthritis Headaches Depression

Asthma/COPD Neuritis Drug Abuse Nervousness Stroke Mental Illness Stomach Ulcer

Osteoporosis Reflux/Heartburn Anemia Digestive Disorder Nerve Problems Cancer

Thyroid Bleeding Disorder Other: _____

Are you currently on any medications? YES/NO If yes, please list the medication and dose:

Medication:	Dosage:

Do you have any allergies/ drug allergies? _____

Lifestyle:

Current Smoker:	Y/N If yes, How many packs per day?
Alcohol Intake:	Y/N If yes, How so often?
Exercise:	Y/N If yes, How many days a week?

Surgical History:

Surgery/Procedure:	Date:

Family History: List any medical problems for family in corresponding box. (high blood pressure, diabetes, etc.)

Mother:	
Father:	
Siblings:	

Reason for today's visit:

Current Pain Conditions. Please provide as much detail regarding your current pain as possible.			
What cause your symptoms to start?			
When did your symptom(s) appear?	Condition is getting: Better, Worse, Same, don't know?	Has it occurred before? Y/N If yes, When?	Additional Comments:
What relieves the pain? Heat, Cold, Rest, Massage, Exercise, Other: _____	What makes the pain worse? Weather, Heat, Cold, Movement, Other: _____	What activities are painful to perform? Lying, Sitting, Standing, Walking, Bending, Other: _____	What routines does this pain interfere with? Work, Sleep, Recreation, Other: _____

HIPAA FORM

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES PURSUANT TO 45 C.F.R.S 64.520

1. **Our Duties**

We are required by law to maintain the privacy of your Protected Health Information ("Protected Health Information"). We must also provide you with notice of our legal duties and privacy practices with respect to Protected Health Information. We are required to abide by the terms of our Notice of Privacy Practices currently in effect. However, we reserve the right to change our privacy practices in regard to Protected Health Information and make new privacy policies effective for all Protected Health Information that we maintain. We will provide you with a copy of any current privacy policy upon your written request, address to our Privacy Officer, at our current address.

2. Your Complaints

You may complain to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with us by sending a certified letter addressed to "Privacy Officer" at our current address, starting what Protected Health Information you believe has been used or disclosed improperly. You will not be retailed against for making a complaint. For further information you may contact out Privacy Officer, at telephone number is 214-821-3591.

3. Description and Examples of Uses and Disclosures of Protected Health Information

Here are some examples of how we may use your medical history, symptoms, injuries or diseases to treat your current condition. In connection with payment, we will, for example, send your Protected Health Information to your insurer or to a federal program, such as Medicare, that pays for your treatment. This allows us to obtain payment for the services we rendered on your behalf. In connection with health care operations, we will, for example, allow our auditors, consultants, or attorneys' access to your Protected Health Information to determine if we billed you accurately for the services we provided to you.

4. Uses and Disclosures Which Require Your Written Authorization

Uses and disclosures other than those involving treatment, payment, and health care operations, we well as those described in the following sections of this Notice, will only be made by obtaining a written authorization from you. You may revoke the authorization in writing at any time, except to the extent that we have taken action in reliance upon your authorization.

5. Uses and Disclosures Not Requiring Your Written Authorization

The privacy regulations give us the right to use and disclosure your Protected Health Information if: (i) you are an inmate in a correctional institution; (ii) we have a direct or indirect treatment relationship with you, (iii) we are so required or authorized by law. The purposes for which we might use your Protected Health Information would be to carry out treatment, payment, and health care operations similar to those described in Paragraph 1.

6. Uses of Protected Health Information to Contact You

regarding appointment reminders or to contact you with information about treatment alternatives or other health-related benefits and services that, in our opinion, may be of interest to you. We may use your Protected Health Information to contact you in an effort to raise funds for our operations.

7. Disclosures of Protected Health Information for Billing Purposes

We may disclose your billing information to any person that calls our billing staff or agents with billing questions after we verify the identity of the person by requesting information such as your social security number or health plan number.

8. Disclosure for Directory and Notification Purposes

If you are incapacitated or not present at the time, we may disclose your Protected Health Information (a) for use in a facility directory, (b) to notify family or other appropriate persons of your location or condition, and (c) to inform family, friends or caregivers of information relevant to their involvement in your care or payment for your treatment. If you are present and not incapacitated, we will make the above disclosure, as well as disclose any other information to anyone you have identified, only upon your signed consent, your verbal agreement, or the reasonable belief that you would not object to such disclosure(s).

9. Individual Rights

(i)You may request us to restrict the uses and disclosures of your Protected Health Information, but we do not have to agree to your request, (ii) You have the right to request that we communicate with you regarding your Protected Health Information in a confidential manner or pursuant to an alternative means, such as by a sealed envelope rather than a postcard, or by communicating to a specific phone number, or by sending mail to a specific address. We are required to accommodate all reasonable requests in this regard. (iii) You have the right to request that you be allowed to inspect and copy your Protected Health Information as long as it is kept as a designated record set, and as long as you pay in advance for the administrative time and costs to make arrangements to have the records inspected and copied. Certain records are exempt from inspection and cannot be inspected or copied, so each request will be reviewed in accordance with the standards published in 45 C.F.R.s 164.524. (iv) You have the right to amend your Protected Health Information for as long as the Protected Health Information is maintained in the designated record set, We may deny your request for an amendment if the Protected Health Information was not created by us, or is not part of the designated record set, or would not be available for inspection as described under section 45 C.F.R.S 164.52, or if the Protected Health Information is already accurate and complete without regard to the amendment. (v) You have the right to request, and thereafter receive, and accounting of the disclosures of your Protected Health Information for six years before the date on which you request the accounting. An exception to this accounting to this accounting are those disclosures not allowed by law pursuant to section of 164.528. Each request for an accounting will be reviewed pursuant to the rules of section 164.528. (vi) You also have a right to receive a copy of this Notice upon request.

10. Effective Date

The effective date of this Notice is July 28, 2018.

Patient/Guardian Signature Date

PATIENT RESPONSIBILITY DISCLOSURES CANCELLATION/ NO SHOW POLICY

PATIENT RESPONSIBILTY DISCLOSURES

Patient Financial Responsibility: In order to provide the highest quality of care, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful and encourage you to discuss it with us and to ask questions. Please understand the financial responsibility for medical services rests between **you and your health plan**. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be financially responsible for this bill after service have been rendered. It is your responsibility as the patient to pay the denied amount in full. **You are expected to pay at the time of service, unmet deductible amounts/co-pays and co-insurance percentages for in-network benefits. ALL PAYMENTS ARE EXPECTED AT APPOINTMENT.** Credit card payment plans are available and further information can be obtained by calling the main office at 214-821-3591. The remainder of your bill will be sent to your health plan for direct payment to out office. If by mistake, your health plan remits payments to you, you will send it to us along with all documentation which accompanied it. Your health plan may refuse payment of a claim for some of the following reasons, among others: (i) You have not yet met your deductible for the full calendar year (ii) The type of medical service required is not covered by your plan (iii) The health plan was not in effect at the time of the service and/or (iv) You have other insurance which must be filled first. If a payment is made on an account by check, and the check is returned as Non- Sufficient Funds (NSF) or Account Closed (AC), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $35.00 Service Charge.

Non-Payment on Account: Accounts that are over 90 days past due may be placed with an outside collection agency for recovery. Should collect proceedings or other legal action become necessary to collect an overdue account, the patient or the Patient's Responsible Party, understands the Magnolia Pain Associates has the right to disclose to an outside, collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the Patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, collection fees, all costs and attorney fees.

Prescriptions and/or Refills: For medical urgent situations and emergencies we advise you to go to the nearest emergency room or to call 911. There is no overnight or call coverage. PLEASE REPORT TO THE NEAREST EMERGENCY ROOM

For non-emergency questions, clinical information, or prescription refills please call us during office hours. As a reminder there are no medication refills after hours or on weekends, please allow 48 hours to process your request. On all refills, please call your pharmacy and request your refill and your pharmacy will then notify us with the appropriate information needed to handle your request. We recommend calling a week in advance. New prescription requests, if possible should be discussed during an office visit. Please note that we DO NOT refill prescriptions on the weekends or holidays. Weekends begin at 4:00PM on Fridays and a holiday begins at 4:00PM on the day prior to National Holiday. In person drug testing/screening is required in specific instances as per your physician.

Authorization/Referral Policy: Please understand that it is your responsibility to obtain an authorization and/or referral through your primary care physician's office, if required by your insurance company. Failure to do so may result in charges being billed directly to you or your appointment being cancelled and rescheduled once you have obtained the appropriate authorization and/or referral.

Medicaid: Magnolia Pain Associates is not in network with Medicaid. Patients with Medicaid will be responsible for the amount that is covered by Medicaid. Sorry for the inconvenience that this may cause.

_____ **(patient initial Medicaid Patients)** I understand Magnolia Pain Associates is accepting me as a private pay patient for the period that I choose to come to the office, and I will be responsible for paying for any services I receive. The provider will not file a claim to Medicaid for services provided to me.

Limitation of Patient Physician Relationship

I understand that Magnolia Pain Associates is subspecialized in and restricted to the areas in which the physicians are fellowship board certified: pain management. I agree to hold Magnolia Pain Associates harmless for any and full failure to diagnose, treat or disclose any medical conditions or other conditions that are not part of this clinic restriction, which includes, but not limited to all non pain management. I further understand and agree that our patient physician relationship is limited to the management of those medical problems that Magnolia Pain Associates agrees to treat. I understand and agree that Magnolia Pain Associates has the right to refuse to diagnose/ treat any additional problems that I may have or may develop in the future, unless It is agreed upon to the time of such occurrence.

CANCELLATION/ NO SHOW POLICY

As a specialty physician office, we reserve your appointment time for you and we expect you to keep all your appointments with the exception of serious emergencies. If you need to re-schedule or cancel an appointment we require 24 hours' notice. **There is an automatic $50.00 (office appointments) or $100.00 (procedure) fee for late cancellation and no-shows which must be paid prior to seeing us at your re-scheduled appointment in addition to any of your insurance deductible and co-payment obligations immediately due.**

I certify that information on these forms, in partial and entirety has been answered truthfully and completely to the best of my knowledge. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier. I have READ AND AGREE to the Patient Responsibility Disclosure and the Cancellation/ No Show Policy.

_____

Patient/Guardian Signature Date

PATIENT CONSENT TO TREATMENT

By reading and signing his document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s), and I acknowledge and consent to the following:

1. **INDEPENDENT CONTRACTORS:** MAGNOLIA PAIN ASSOCIATES may utilize independent contractors for office, outpatient or inpatient treatment/ procedures. These include, but are not limited to, surgical assistants, physical therapists, and consulting and referral physicians. Healthcare professionals that are independent contractors are not agents or employees of MANGOLIA PAIN ASSOCIATES are responsible for their own actions. I understand that MAGNOLIA PAIN ASSOCIATES shall not be liable for the acts or omissions of independent contractors. This Consent to Treatment also applies to any independent contractor utilized by my physician(s).
2. **VALUABLES:** MAGNOLIA PAIN ASSOCIATES assume no responsibility for, and I herby release MAGNOLIA PAIN ASSOCIATES for liability for, loss, or damage to any of my personal property while on the premises and/or receiving treatment.
3. **AUTHORIZATION FOR RELASE OF INFORMATION AND ASSIGNMENT OF THE THIRD-PARTY PAYMENTS:** I hereby expressly authorize MANGOLIA PAIN ASSOCIATES and all healthcare professionals providing care to release all necessary information to MAGNOLIA PAIN ASSOCIATES any insurance company, health plan or other entity (third party payor) which may be responsible or paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to MAGNOLIA PAIN ASSOCIATES and all professionals (including independent contractors) providing for

such care, and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to MAGNOLIA PAIN ASSOCIATES and the third-party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.

4. **PAYMENT FOR SERVICES:** In return for services to be provided by MAGNOLIA PAIN ASSOCIATES I promise to pay for services rendered by MAGNOLIA PAIN ASSOCIATES to me or for my benefit. If the services I receive from MAGNOLIA PAIN ASSOCIATES are covered by a third-party payor, MAGNOLIA PAIN ASSOCIATES may elect to bill and accept payment from such third-party. I will pay the portion of these bills which the third-party payor determines are my responsibility. In the case of services which I agree to receive but which are not covered by the third party, I will pay the amount due upon receipt of services. If no third-party is involved in paying for my services, I agree to pay in full for such services at the time the services are received. I also understand that my account must be in good standing, without balance for medical records release. A fee will apply for records.
5. **AUTHORIZATION ND RELEASE FOR PHOTOGRAPHS:** I authorize and release MAGNOLIA PAIN ASSOCIATES and its employees and agents to take images may be used for educational or other purposes as necessary and appropriate. These images may be maintained as a permanent part of my medical record. I understand and acknowledge that MAGNOLIA PAIN ASSOCIATES may use cameras for security and patient monitoring, and patient confidentiality will be maintained for all such images.
6. **NO GUARANTEE OF RESULTS:** MAGNOLIA PAIN ASSOCIATES physicians and healthcare professionals cannot guarantee any specific result(s) of any examination, treatment, procedure or medical care. I release MAGNOLIA PAIN ASSOCIATES or its employees, agents, representatives or assigns.
7. During the course of my care and treatment, I understand that various types of examinations, tests, diagnostic or treatment procedures ("procedures") may be necessary. These procedures may be performed by physician(s), nurses, technicians, physician assistants, or other healthcare concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.
8. I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

By Signing this document, I certify that I have read and understand its content and the information provided by me is accurate and complete (including insurance information and current eligibility for benefits).

A copy of this document may be utilized the same as the original.

Parent/Guardian Signature Date

If not signed by the patient, please indicate relationship to the patient: