GENERAL HISTORY **Time Completed**_____

DATE: _____

NAME: _____ DOB: _____ AGE: _____

REASON FOR YOUR VISIT TODAY: _____

DATE OF INJURY/ACCIDENT/ILLNESS: _____

WORK RELATED: _____ AUTO ACCIDENT: _____

ACCIDENT INFORMATION: _____

HAVE YOU RECEIVED ANY TREATMENT PRIOR TO TODAY? _____ IF SO BY WHOM? _____

DESCRIBED TREATMENT RECEIVED? _____

HAVE YOU HAD XRAYS FOR THIS COMPLAINT? _____ IF SO WHERE? _____

DO YOU SMOKE? _____ NUMBER OF PACKS A DAY? _____ NUMBER OF YEARS A SMOKER? _____

DOMINANT HAND? LEFT _____ RIGHT _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?
IF YES, PLEASE CIRCLE:

BLOOD CLOTTING PROBLEMS

BLOOD TRANSFUSION? _____ DID YOU REACT? _____

CHEST PAIN OR IRREGULAR HEARTBEAT

CHRONIC OR PERSISTANT COUGH

CONVULSIONS, THYROID, LOW BLOOD COUNT

DIABETES, SEIZURES, HIGH BLOOD PRESSURE

HEART ILLNESS OR HEART ATTACK

HEPATITIS, JAUNDICE, LIVER DISEASE

KIDNEY DISEASE, SHORTNESS OF BREATH

SWELLING AND/OR PAIN IN THE JOINTS

WEAKNESS, PARALYSIS, NUMBNESS

FAMILY MEDICAL HISTORY

(FATHER, MOTHER, OR SIBLINGS)

ANESTHESIA PROBLEMS? _____ ARTHRITIS? _____

BLEEDING DISORDERS? _____ BLOOD CLOTTING? _____

CANCER ? _____ IF SO, WHAT TYPE? _____

ALLERGIES:

MEDICATIONS:

SURGERIES:

Patient Information

Date _____

Name-First, Middle, Last **(Please Print)**	Soc. Security #	Marital Status S M W D Sep	Birth Date ___/___/___	Age	Sex M F
Street Address	City/State		Zip Code	Home/Cell #	
Patient's Employer	Occupation		How long employed	Work phone/ext	
Employer's Address	City/State		Zip Code	Supervisor Dept	
Family Physician/Address/Phone	Home email				
Spouse	S.S. #		Referred by		
Spouse Employer	Occupation		How long employed	Work phone	
Employer's Address	City/State		Zip Code		
Nearest Friend/Relative-Not Living With You	City/State		Home phone #	Cell#	
Injured on the Job? Y N	Date of injury		Work Comp Contact/Phone #		
Auto or other accident? Please indicate	Date of accident		Attorney/Phone#		

Responsible Party

___ Spouse, Listed Above ___ Guardian ____ Other, Shown below

I Prefer to Pay With
___ Cash ___ Visa/MC ___ Discover

Name-First, Middle, Last **(Please Print)**	Date of birth	Relationship
Address		Soc. Sec. #
Employer's Address	Home/Work Phone #	Cell Phone #

Insurance Information

Do you have health insurance? Y N (If yes, please complete the following)			
Primary Insurance Carrier or Medicare/Medicaid			
Policy No., (ID No)	Group No.	Co-pay Amount	
Insurance Co Address	City/State	Zip Code	Phone
Name of Policy Holder Relationship	Soc. Sec. #	Date of Birth	
Secondary Insurance Carrier			
Policy No., (ID No)	Group No.	Co-pay Amount	
Insurance Co Address	City/Sate	Zip Code	Phone
Name of Policy Holder Relationship	Soc. Sec. #	Date of Birth	

Patient Authorization

I authorize payment of medical benefits to Dr Randall P. Frazier, Dr John E. Foropoulos, Dr James N. Long, Dr. Bruce S. Senter. Dr. Wendy C. Nethery, Brittany B. Bryant, F.N.P., and/or Robin Arnwine, Physical Therapist for services provided. I also authorize the release of any medical information necessary to process this claim. I understand and agree any unpaid balance not covered by insurance will be paid by me.

_____ _____

SIGNATURE (Insured of Authorized Person) Date

1. What information you want to limit;
2. Whether you want to limit our use, disclosure or both;
3. To whom you want the limits to apply (for example, disclosures to your spouse).

You also have a right to request that a health care item or service not be disclosed to your health plan for payment purposes or health care operations. We are required to honor your request **IF** the health care item or service is paid out of pocket and in full. Your restriction will only apply to records that relate solely to the service for which you have paid in full. We are not required to agree to any other request, and will notify you if we are unable to agree. If we agree to your request, we must follow your restrictions (unless the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time, unless it relates to a health care item or service that is paid out of pocket and in full, as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

- **Right to Request Confidential Communication**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
  For example: You can ask that we only contact you at work or by mail.
  To request confidential communications, you must make your request in writing to the Facility Medical Records Department or Facility Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice**. You have the right to a copy of this Notice. You may ask us to give you a copy at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

- **Right to Receive Notice of a Breach**. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breach of your unsecured protected health information.

- **Facility Privacy Officer**. If you have any questions about this Notice, please contact the Facility Privacy Officer at: **Magnolia Orthopaedics and Sports Medicine Clinic, P.A. 611 Alcorn Drive Suite 100 Corinth, MS 38834, 662-286-6369.**

Effective Date of Notice: August 28, 2013

_____ _____

NAME DATE

REVISED 8.28.2013

Personal Representative Authorization

Other than yourself to whom may we give information to about test results, prescriptions, appointment dates and times, medical records and forms of any kind.

ID REQUIRED FOR ANY RELEASE OF INFORMATION, FOR PROOF OF PERSONAL REPRESENTATIVE.

1. _____ relation: _____ phone number: _____
2. _____ relation: _____ phone number: _____
3. _____ relation: _____ phone number: _____

NOTE: If a person is NOT listed above NO information can or will be released to them!

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices and Personal Representative Authorization:

Print Name: _____ Signature: _____ Date: _____

Magnolia Orthopaedics & Sports Medicine Clinic, P.A.

611 Alcorn Drive, Suite 100
Corinth, MS 38834
(662) 286-6369
(800)961-2278
FAX (662) 286-276

Randall P. Frazier, M.D., F.A.A.O.S. John E. Foropoulos, M.D., F.A.A.O.S. Bruce S. Senter, M.D. F.A.A.O.S.
James N. Long, M.D.F.A.C.S. Wendy M. Nethery, D.P.M. Brittany B. Bryant, F.N.P. Robin D. Arnwine, PT

FINANCIAL POLICY

Dear Patient,

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our office staff.

In most instances, we accept assignment of insurance benefits and do the billing for you. However, you must understand that:

1) Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract; our relationship is with you, not the insurance company.

2) If no payment is received after 30 days, we will refile the claim. If no payment is received after 60 days, the balance is your responsibility to pay by cash, check, or credit card.

3) Deductibles and co-payments will be collected at the time services are rendered; this will be determined at your initial visit. Self pay patients need to pay for services in full at the time services are rendered.

4) Beginning January 1, 2015, a service charge of 1 1/2% will be added to balances over 60 days old.

5) All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurances arbitrarily select certain services they will not cover, and most charges are subject to usual and customary fees.

6) Returned checks are subject to a fee of $25.00. As long as we receive a money order or a cash payment within a week of receiving notification, no service fee will be charged. This is your responsibility to correct. No notice will be sent out by the office.

7) We do NOT accept liens. We are happy to cooperate with attorneys to help settle cases, but payment will be made at the time services are rendered.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____