MAGNOLIA MEDICAL GROUP

8031 PHILIPS HWY., SUITE 6
JACKSONVILLE, FL 32256
P. (904) 737-6313 F. (904) 739-1302

5851 TIMUQUANA RD., SUITE 201
JACKSONVILLE, FL 32210
P. (904) 779-2220 F. (904) 779-2227

CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION

FULL NAME _____ DATE OF BIRTH _____ AGE_____ M____ F____

ADDRESS _____ APT# _____ SSN _____-_____-_____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____ BEST # TO CALL : ☐ HOME ☐ CELL

EMAIL: _____

PREFERENCE FOR APPOINTMENT REMINDER: ☐ CALL ☐ TEXT ☐ BOTH

EMPLOYERS NAME _____ OCCUPATION _____

WORK ADDRESS_____WORK PHONE _____ IS IT OKAY TO CALL WORK? Y__ N__

PHARMACY YOU USE _____ PHARMACY PHONE NUMBER _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED

RACE: _____ ETHNICITY:_____

EMERGENCY CONTACT _____ PHONE_____

CLAIM INFORMATION

IS YOUR CONDITION DUE TO A (AN): AUTO ACCIDENT _____ PERSONAL INJURY _____ WORK INJURY _____

DATE OF ACCIDENT:_____CAR ACCIDENT CLAIM NUMBER: _____ STATE ACCIDENT OCCURRED IN: _____

INSURANCE INFORMATION

RELATIONSHIP TO POLICY HOLDER: SELF_____ SPOUSE _____ CHILD _____ OTHER _____

POLICY HOLDER NAME _____ DATE OF BIRTH _____

PRIMARY INSURANCE COMPANY _____

POLICY # _____ GROUP NUMBER _____

SECONDARY INSURANCE COMPANY _____

POLICY NUMBER _____ GROUP NUMBER _____

AUTHORIZATIONS: PLEASE READ CAREFULLY

A. I hereby authorize the release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefits from third parties for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereby owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment on my behalf based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charges made directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

PATIENT SIGNATURE _____ DATE_____

PATIENT HEALTH HISTORY

PATIENT NAME _____ DATE OF BIRTH _____

HEALTH HABITS

EXERCISE: ☐NONE ☐MILD (CLIMB STAIRS, WALK 3 BLOCKS, GOLF) ☐OCCASIONAL VIGOROUS (WORK OR RECREATION LESS THAN 4X WKLY FOR 30 MIN) ☐REGULAR VIGOROUS (WORK OR RECREATION 4X WKLY FOR 30 MIN)

ARE YOU DIETING? YES☐ NO☐ IF YES, ARE YOU ON A PHYSICIAN PRESCRIBED MEDICAL DIET? YES☐ NO☐

CAFFEINE (# OF CUPS/CANS PER DAY): ☐NONE ☐COFFEE ☐TEA ☐COLA _____

DO YOU DRINK ALCOHOL? YES☐ NO HOW MANY DRINKS PER WEEK _____

HOW LONG HAVE YOU BEEN DRINKING? (# YEARS) _____

TOBACCO: DO YOU USE TOBACCO? YES _____ NO _____ # YEARS _____ YEARS QUIT? _____ CIGARETTS PKGS/DAY _____ PIPE #/DAY _____ CIGARS #/DAY _____ CHEW #/DAY _____

FAMILY HISTORY: HAS ANY BLOOD RELATIVE EVER HAD THE FOLLOWING:

BREAST CANCER	YES☐ NO ☐	DIABETES	YES☐ NO ☐
OVARIAN CANCER	YES☐ NO ☐	KIDNEY DISEASE	YES☐ NO ☐
STROKE	YES☐ NO ☐	DEPRESSION	YES☐ NO ☐
HIGH BLOOD PRESSURE	YES☐ NO ☐	MELANOMA	YES☐ NO ☐
HEART DISEASE	YES☐ NO ☐	OTHER _____	

PAST MEDICAL HISTORY: HAVE YOU EVER HAD THE FOLLOWING:

HEART DISEASE	YES☐ NO ☐	DEPRESSION	YES☐ NO ☐	HEPATITIS	YES☐ NO ☐
HIGH CHOLESTEROL	YES☐ NO ☐	HEART ATTACK	YES☐ NO ☐	HIGH BLOOD PRESSURE	YES☐ NO ☐
SINUS TROUBLE	YES☐ NO ☐	DIABETES	YES☐ NO ☐	SEIZURES	YES☐ NO ☐
CHEST PAIN	YES☐ NO ☐	CHRONIC FATIGUE	YES☐ NO ☐	LUNG PROBLEMS	YES☐ NO ☐
URINARY DISORDERS	YES☐ NO ☐	KIDNEY STONES	YES☐ NO ☐	EMPHYSEMA/COPD	YES☐ NO ☐
SWOLLEN ANKLES	YES☐ NO ☐	CANCER	YES☐ NO ☐	VISION PROBLEMS	YES☐ NO ☐
BLOOD CLOTS	YES☐ NO ☐	STOMACH ULCER	YES☐ NO ☐	STD HISTORY	YES☐ NO ☐
GASTRIC REFLUX	YES☐ NO ☐	HEARTBURN	YES☐ NO ☐	HEADACHES	YES☐ NO ☐
DIVERTICULITIS	YES☐ NO ☐	GLAUCOMA	YES☐ NO ☐	GOUT	YES☐ NO☐
ARTHRITIS	YES☐ NO ☐	KIDNEY DISEASE	YES☐ NO ☐	PALPITATIONS	YES☐ NO ☐
ULCER	YES☐ NO ☐	LEG BLOOD CLOTS	YES☐ NO ☐	SLEEP PROBLEMS	YES☐ NO ☐
BACK PAIN	YES☐ NO ☐	ASTHMA	YES☐ NO ☐	FAINTING/DIZZY SPELLS	YES☐ NO☐
TUBERCULOSIS	YES☐ NO ☐	THYROID DISEASE	YES☐ NO ☐	CONSTIPATION	YES☐ NO ☐
EYE DISEASE	YES☐ NO ☐	BLOOD STOOL	YES☐ NO ☐	GASTRIC REFLUX	YES☐ NO ☐
FOOT PAIN	YES☐ NO ☐	AIDS OR HIV	YES☐ NO ☐	ALLERGIES	YES☐ NO ☐
RHEUMATIC FEVER	YES☐ NO ☐	BLEEDING TENDENCY	YES☐ NO ☐	ABDONIMAL PAIN	YES☐ NO ☐
LIVER DISEASE	YES☐ NO ☐	HEMORRHOIDS	YES☐ NO ☐	OSTEOPOROSIS	YES☐ NO ☐
HEARING PROBLEMS	YES☐ NO ☐	STROKE	YES☐ NO ☐	GALLBLADDER	YES☐ NO ☐
ANEMIA	YES☐ NO ☐	MITRAL VALVE PROLAPSE	YES☐ NO ☐		
DRUG ADDICTIONS	YES☐ NO ☐	KNEE PAIN	YES☐ NO ☐		

WOMEN ONLY

BIRTH CONTROL PILLS YES ☐ NO ☐ NUMBER OF CHILDREN _____

LAST MENSTRUAL PERIOD _____ DATE OF LAST MAMMOGRAM _____

BREAST LUMP OR DISCHARGE _____ DATE OF LAST PAP _____

CURRENT MEDICATIONS (INCLUDING OVER THE COUNTER DRUGS, ASPRIN AND NASAL SPRAYS)

DRUG NAME	DOSAGE	TIMES PER DAY

MEDICATION ALLERGIES	TYPE OF REACTION

NON-MEDICATION ALLERGIES	TYPE OF REACTION

PAST SURGICAL HISTORY

SURGERY	YEAR

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RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (i.e., narcotics, tranquilizers and barbiturates) are very useful in relieving pain, thus improving function and/or ability to work. They have a high potential for misuse and are, therefore, closely controlled by local, state and federal government. Because my physician is prescribing controlled substance medications to help manage my pain, I agree to the following conditions:

1. I understand that the risks associated with controlled medications include dependence, addiction, tolerance, constipation, sleep changes, potential for increased pain, risk to unborn children, withdrawal, and changes to appetite, coordination, sexual desire and sexual performance.

2. I will not share, sell or trade my medication with anyone and I will not alter my prescriptions under any circumstance.

3. I will not obtain pain medication from any other physicians. Doing this will constitute a breach of this contract and will immediately end any and all responsibility on behalf of my physician for further care.

4. I understand that if I break any portion of this agreement, my doctor will stop prescribing these pain-control medicines and may elect to discharge me from the office.

We will also release any necessary medical records to authorities to assist in possible prosecution. I agree to follow these guidelines; which have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be provided to me upon request.

Patient Signature _____ Date _____

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AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION AND AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

This is a full and unconditional assignment of all of my rights and benefits under any insurance policy to Vincent Galiano M.D., P.A. This assignment is for all past, present and future care.

I hereby grant Vincent Galiano, M.D., P.A., or its designated representative(s), the authority to seek, receive and release any and all information pertaining to me as may be necessary to process my insurance claim(s) and to bill and receive payment from my insurance company for any and all services rendered to me by Vincent Galiano M.D., P.A. or its designees.

I hereby agree to pay Vincent Galiano M.D., P.A. in a timely fashion, for any and all services rendered which may or may not be covered by my insurance. This includes all co-payments and/or insurance payments which I may receive as a result of services rendered by Vincent Galiano M.D., P.A. I further agree that if collection becomes necessary, I will pay all cost of collection of my balance including reasonable attorney fees.

CONSENT FOR DIAGNOSITC AND/OR THERAPEUTIC PROCEDURE

I hereby consent to and authorize Vincent Galiano, M.D., P.A. and its designated representative(s) to perform a physical examination and routine diagnostic procedures upon me. I also consent to and authorize Vincent Galiano, M.D., P.A. to prescribe a therapeutic regime, which I shall follow. Unless I explicitly refuse, I consent that the diagnostic procedure(s) ordered by Vincent Galiano, M.D., P.A. to be performed on me, despite the risks and complications that might be involved, which were explained to me at the time that the procedures were ordered.

CONSENT FOR REFERRALS TO SPECIALISTS OR DIAGNOSTIC TESTING

If I am referred out to another doctor for any testing needed, I authorize Vincent Galiano, M.D., P.A. to send the necessary information needed to be treated or for a test to be done. The information sent may include office notes, any previous testing, personal information to contact the patient and billing information.

PLEASE PRINT AND SIGN NAME

Print _____ Date _____

Sign _____ Date _____

Witness _____

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REQUEST FOR MEDICAL RECORDS DR. VINCENT GALIANO, M.D.

DATE _____

TO _____

PHONE _____

FAX _____

PATIENT NAME _____

DATE OF BIRTH _____

SSN _____

I HEREBY REQUEST THE FOLLOWING RECORDS TO BE RELEASED TO:

NAME _____

PHONE _____

FAX _____

PATIENT SIGNATURE _____ DATE _____

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OFFICE POLICY FOR PAYMENT OF SERVICES AND SUPPLIES

Payment(s) for services rendered are the responsibility of the patient. If we are a participating provider, we will process and file you insurance claims. Upon receipt of insurance payment your statement balance will be mailed to you. Balances must be paid within 15 days of billing. There is a twenty- dollar ($20) fee for all returned checks. Copayments and deductibles are due prior to seeing the doctor.

APPOINTMENT CANCELLATION POLICY

Our office must be given notice that you intend to cancel your appointment at least twenty-four (24) hours in advanced. Failure to give notice of cancellation will result in a twenty-five dollar ($25) charge.

Thank you for your understanding and consideration

Patient Signature _____ Date_____

Patient Name _____

Relationship if other than patient _____

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PAYMENT POLICY

Thank you for choosing Dr. Vincent Galiano as your primary care provider. We are committed to providing you with quality and affordable health care. Please read this payment policy, ask us any questions you may have, and sign in the space provided.

1. Insurance. We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan that we can't verify coverage, payment is due in full until coverage can be verified. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payments at each visit.

3. Non-covered services. Please be aware that some, and perhaps all, of the services your receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account if over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family member may be discharged from this practice. If this is to occur, you will be notified by regular mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not cancelled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to service you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party Date

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of consent: by signing this form, you will consent to our use and disclosure on your protected health information (PHI) to carry out treatment, payment activities and healthcare operation. Notice of privacy practices: You have the right to read our Notice of Privacy Practices before you decide to sign this consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, and the uses and disclosures we may make of your PHI and of other important matters about your PHI. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing the consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, which will contain the changes. Those changes may apply to any or our PHI that we maintain.

Right to revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation. Understand that we may decline to treat you or to continue to treat you if you revoke this consent.

I, _____(print), have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my PHI to carry out treatment, payment activities and healthcare operations. I also authorize my healthcare provider to discuss or release my PHI to anyone listed below.

Name and relationship _____

Name and relationship _____

Name and relationship _____

Name and relationship _____

Name and relationship _____

Signature _____ Date _____