Magnolia Psychiatry and Mental Wellness

602 E Academy St., Ste. 205 Fuquay-Varina, NC 27526

(919)-635-6202

Patient Information	**Responsible Party Information**
Name :	**Name:**
First Middle Last	First Middle Last
Date Of Birth: Sex: **M** ☐ **F** ☐	**Relationship :**
	Date Of Birth: Sex: **M** ☐ **F** ☐
Social Security #	Social Security #
Home Address:	Home Address:
City State Zip	City State Zip
Mailing Address:	
Home Phone : Message	Home Phone: Message
Employer name:	Employer name:
Address:	Address:
City State Zip	City: State Zip
Work Phone:	Work Phone:
Email Address(required):	Email Address:

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

PRIMARY INSURANCE ID _____ SECONDARY INSURANCE ID _____

Emergency Contact Person & Phone number _____

I certify that the information contained on this form is correct to the best of my knowledge. Furthermore, I authorize the release of any medical information necessary to process this claim for treatment, payment, or operations. I authorize payment of medical benefits to Magnolia PMW provider or suppliers for services. I, the undersigned, hereby authorize the provider and whomever else he may designate as his assistant (s), to administer those treatments and procedures which in his/her opinion are deemed necessary. I hereby agree, regardless of insurance coverage, that I am responsible for all charges incurred. Payment is EXPECTED at the time of service. We will bill your insurance as a courtesy. I provide my consent for Magnolia Psychiatry and Mental Wellness, to share relevant medical information with the North Carolina Immunization Registry and its partners.

Patient Signature _____ **Date** _____

Responsible Party's Signature _____ **Date** _____

Witness _____ **Date** _____

Magnolia Psychiatry and Mental Wellness

Documents: Consent for Services

Instructions From Practice: Please read the following Consent for Services form carefully. This form reviews many important policies and procedures related to your treatment. It also reviews the risks and benefits of treatment, limits of confidentiality, cancellation requirements, and billing practices. Make sure to review the contents of this form at your first session to ask any questions or obtain clarification as needed.A copy of the consent is available in the portal. Once you have read this form, please sign and submit.

Patient:
DOB:
Date:

This form is called a Consent for Services (the "Consent"). Your Provider has asked you to read and sign this Consent before you start treatment. Please review the information. If you have any questions, contact your Provider.

THE THERAPY/MEDICATION MANAGEMENT PROCESS

Therapy is a collaborative process where you and your Provider will work together on equal footing to achieve goals that you define. This means that you will follow a defined process supported by scientific evidence, where you and your Provider have specific rights and responsibilities. Therapy generally shows positive outcomes for individuals who follow the process. Better outcomes are often associated with a good relationship between a client and their Provider. To foster the best possible relationship, it is important you understand as much about the process before deciding to commit.

Therapy begins with the intake process. First, you will review your Provider's policies

Sign Form X_____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number:_____ CVV_____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

Our policy requires the collection of copays at the time of service. While billing may occasionally experience delays due to insurance processing (which can take up to 90 days) and other factors, this will not affect the agreed-upon payment arrangement. The practice may charge any outstanding balances, including late cancellation or no-show fees, to the payment method on file without further authorization. The card on file is necessary for accountability regarding any additional fees, court fees, no-show fees, deductibles, outstanding balances, and out-of-pocket expenses. We reserve the right to charge the card on file, even if it was not swiped at the time of service.

Customer Signature _____

Date _____

Magnolia Psychiatry and Mental Wellness

Documents: Notice of Privacy Practices

Instructions From Practice: Please review the notice of privacy practices and sign, then submit below.

Patient:
DOB:
Date:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. A COPY IS AVAILABLE IN THE PORTAL. PLEASE REVIEW IT CAREFULLY.

Magnolia Psychiatry and Mental Wellness (the “Practice”) is committed to protecting your privacy. The Practice is required by federal law to maintain the privacy of Protected Health Information (“PHI”), which is information that identifies or could be used to identify you. The Practice is required to provide you with this Notice of Privacy Practices (this “Notice”), which explains the Practice's legal duties and privacy practices and your rights regarding PHI that we collect and maintain.

YOUR RIGHTS
Your rights regarding PHI are explained below. To exercise these rights, please submit a written request to the Practice at the address noted below.

Sign Form X_____

Magnolia Psychiatry and Mental Wellness

602 East Academy Street, Suite 205
Fuquay Varina, NC 27526
P: (919)635-6202
F: (919) 289-1713

AUTHORIZATION FOR THE RELEASE OF BENEFICIARY INFORMATION

I request that my information be released to **Magnolia Psychiatry and Mental Wellness**. This authorization expires twelve months from the date of signature or when I am no longer a client of Magnolia Psychiatry and Mental Wellness**,** whichever comes first. I have the right to revoke this authorization at any time. Information that is disclosed is subject to re-disclosure and no longer protected by the privacy regulations (45 CFR 145).

Purpose of Release: The information will be used and disclosed only for purposes of (a) coordinating appropriate and effective care, treatment, or habilitation, and (b) quality assessment and improvement activities, which may include, but are not limited to, direct patient care, case management and care coordination, disease management**,** outcomes**,** evaluations**,** development of clinical guidelines and protocols, development of case management plans and systems, and the provision, coordination, or management of health**,** mental health, developmental disabilities, and related services.

Types of Information to be Shared

Entire treatment record
Current status and location
Diagnosis
Treatment plan
Psychological evaluations
Discharge summary
Provider/Hospital records
Social history
School/Criminal records
Billing statements
Other
Purpose of Disclosure
Continuity of care
Emergency management
Account management
Legal/Court order
Other

Authorization
I hereby authorize Magnolia Psychiatry and Mental Wellness to release information as described above to, and request information from, the person or organization identified herein. I understand that the person or organization named above may not be subject to the same privacy laws and regulations as Magnolia Psychiatry and Mental Wellness and may be able to further share the information disclosed under this authorization. I request that my information be released to Magnolia Psychiatry and Mental Wellness. I consent to use electronic signatures, and my signature below is the same as a handwritten signature for the purposes of validity, enforceability, and admissibility. This authorization expires twelve months from the date of signature or after 30 days of when I am no longer a client of Magnolia Psychiatry and Mental Wellness, whichever comes first. I have the right to revoke this authorization at any time. Information that is disclosed is subject to re-disclosure and no longer protected by the privacy regulations (45 CFR 145).

Purpose of Release: The information will be used and disclosed only for purposes of (a) coordinating appropriate and effective care, treatment, or rehabilitation, and (b) quality assessment and improvement activities, which may include, but are not limited to, direct patient care, case management and care coordination, disease management, outcomes, evaluations, development of clinical guidelines and protocols, personal request, legal/court order, emergency contact, development of case management plans and systems, and the provision, coordination, or management of health, mental health, developmental disabilities, and related services.

Duration and Revocation of Authorization

This authorization is good for a period of [1 year].].
I understand that I can revoke this authorization at any time prior to that date by contacting the practice in writing.

I understand that if the practice has already shared the information authorized here at the time I revoke this authorization, then it is too late to prevent that information from being shared.

I understand that the practice cannot make completion of this authorization a condition for any treatments or benefits I am entitled to, unless this authorization is necessary to determine eligibility for treatment or benefits or to pay for treatments I receive.

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely.

I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

Signature of Individual/ Guardian Date:

Signature of Witness Date:

Send request to the address of fax number listed above. **For questions, please call.**

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