Medical Record # (for office use only)

Magic City Wellness Center

2500 4th Avenue South
Birmingham, AL 35233

New Patient Registration

While Magic City Wellness Center recognizes all genders/identities, many insurance companies and legal entities unfortunately do not. Please be aware that your legal name and sex listed with your insurance must be used on documents pertaining to insurance, billing, and correspondence.

Legal Name: Last_____First_____MI___
Name you go by (if different from legal name): _____
Pronouns:_____

Date of Birth (month/day/year):_____ Social Security #:_____
State ID/License #:_____
Mailing Address: (street and number)_____
(city)_____ (state)_____(zip code)_____
Phone Numbers: (home)_____(cell)_____(work)_____
Best number to use? (home)____ (cell)____ (work)____
Email Address:_____

Sex assigned at birth (place "x" next to one): Female_____ Male_____
What is your Gender Identity? (place "x" next to one): Cis Female____ Cis Male____ Trans Female____
Trans Male____ Non Binary____ Other (please write)_____

Emergency Contact: (name)_____ (phone number)_____
(relationship)_____
(Does this include mental health? place "x" next to one) YES___ NO___
Who should we NOT contact?_____

Minors Only: (Patient/Guardian Name)_____
(phone number)_____(relationship)_____

<u>This information is for demographic purposes only and will not affect your care at MCWC.</u>

Race/Ethnicity (place "x" next to one): African American/Black____ Caucasian/White____ Multiracial____ Native American____ Pacific Islander____ Asian____ LatinX____ Latino____ Latina____ Spanish____
Other (please write)_____

Sexual Identity (place "x" next to one): (Gay)____ (Straight)____ (Lesbian)____ (Bisexual)____
Other (please write)_____

Consent for Treatment

Patient Name:_____ Date:_____

I hereby give my consent and authorize Magic City Wellness Center to treat any medical or mental health condition providing that the care provider has explained my condition to me, the treatment procedures, and alternative methods of treating my condition. The care provider has discussed with me foreseeable risks of the above stated treatment and that there may be undesirable results. I authorize the care provider to perform any additional or different treatment, which is though necessary should, during treatment, a condition be discovered which was not previously known. I have carefully read and understand this informed consent form and all of my questions have been adequately answered.

Treatment and Data Agreement

- I authorize examination and treatment for this and all following medical or mental health visits.
- I understand I am personally responsible for all charges and deductibles.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serves as the original and the use of this signature on all insurance submissions.
- I authorize release of all information necessary to secure payments of benefits.
- I understand that Magic City Wellness Center may use data developed for and/or provided by clients to determine general characteristics of the communities it serves and that none of this information will identify individual clients.

I certify that the above information is true and correct. I have received a copy of Magic City Wellness Center's "Notice of Privacy Practices (HIPAA)" and Office Policies.

Patient Signature:_____ Date:_____

Witness:_____ Date:_____

PATIENT MEDICAL INFORMATION

Name: _____ Preferred Name:_____

Date of Birth: _____

Personal Medical Information: Are you being treated for any of the following medical conditions? (check next to all that apply)

- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anesthesia Complications
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Cancer
- ☐ Chronic Pain
- ☐ Connective Tissue Disease (eg: RA, Lupus, etc)
- ☐ COPD
- ☐ Defibrillator
- ☐ Dental Issues
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Dependency/Addiction
- ☐ Fibromyalgia
- ☐ Gastrointestinal Disease
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure/Hypertension
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Infections
- ☐ Insomnia
- ☐ Kidney Disease
- ☐ Mental Health Issues
- ☐ Pacemaker
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Strokes/TIA
- ☐ TB
- ☐ Transfusion Reaction
- ☐ Ulcers
- ☐ STD/STI
- ☐ Tobacco Abuse

Review of Symptoms

Please check ALL that apply and have occurred within the last few months for several days:

BLOOD:

- ☐ Anemia
- ☐ Clots
- ☐ Fatigue
- ☐ Free Bleeder
- ☐ History of Clots
- ☐ Polycythemia (thick blood)

CARDIOVASCULAR:

- ☐ Chest Pain
- ☐ Feet/Leg swelling
- ☐ Heart Flutter
- ☐ Irregular Heart Beat
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Syncope

GASTROINTESTINAL:

- ☐ Anorexia
- ☐ Blood in stool
- ☐ Bulimia
- ☐ Change in Appetite
- ☐ Change in Diet/weight
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

GLANDS/HORMONES

- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Menopause
- ☐ Menstrual Irregularities
- ☐ Weight Gain/Loss

MENTAL

- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Insomnia
- ☐ Suicidal Thoughts
- ☐ Homicidal Thoughts

MUSCULOSKELETAL

- ☐ Pain (anywhere)
- ☐ Stiffness
- ☐ Swelling (anywhere)
- ☐ Weakness

NEUROLOGICAL

- ☐ Burning Pain
- ☐ Headaches
- ☐ Neck/Back Pain
- ☐ Numbness
- ☐ Seizures
- ☐ Tingling

OB/GYN

- ☐ Burning
- ☐ Cramps
- ☐ Dyspareunia
- ☐ Itching
- ☐ Pregnancy

RENAL

- ☐ Dialysis
- ☐ Dysuria (painful urination)
- ☐ Frequency (more or less)
- ☐ Incontinence
- ☐ Kidney Stones
- ☐ Urgency

RESPIRATORY

- ☐ Cough
- ☐ Shortness of Breath
- ☐ Trouble Breathing

SKIN

- ☐ Bug Bites
- ☐ Bruising
- ☐ Burns (of any kind)
- ☐ Itching
- ☐ Jaundice
- ☐ Rashes
- ☐ Wounds

PATIENT MEDICAL INFORMATION PAGE 2:

MEDICATIONS:

List all of your current medications and dosage. (Include over the counter, vitamins, herbal supplements, CPAP machines, allergy medications, and anything else you take)

_____

_____

_____

_____

ALLERGIES:

List medication and other allergies (food, latex, etc.) you have as well as the type of reaction (swelling, rashes, etc.)

_____

_____

_____

_____

FAMILY HISTORY:

List all significant illnesses your grandparents, parents, brothers, and sisters have or have had.

Relative Disease/Illness/Disorder Mental and Physical

_____

_____

_____

_____

SURGICAL HISTORY:

Date Operation

_____

_____

_____

_____

SOCIAL HISTORY:

Caffeine intake per day (soda, coffee, tea, energy drinks, etc.) _____

Cigarette/Tobacco Use (List packs per day and number of years you have smoked)_____

Desire to Quit/Any Attempts?_____

Alcohol: (list types and frequency used)_____

Other Substances (note: this form is confidential and will only be shared with your physician in order to address your health care needs):_____

SEXUAL HISTORY:

Are you currently sexually active? Have you ever been?_____

Are your partners men, women or both?_____

How many partners have you had in the last month?_____Six months_____Lifetime_____

Are you satisfied with you or your partners sexual functioning?_____

Has there been any change in you or your partners sexual desire or frequency?_____

Do you have any risk factors for HIV? (STDs, HIV Positive Partner, Needle use, blood transfusion?)_____

Have you ever had an STD/STI?_____

Have you ever been tested for HIV?_____Would you like to be?_____

What preventative measures do you use to protect yourself from contracting an STD/STI?_____

What method of contraception do you use?_____

Are you trying to become pregnant? (or father a child?)_____
Do you participate in Oral Sex?_____Anal Sex?_____
Do you or your partner use any substances or devices to increase sexual pleasure?_____
Do you have any pain during intercourse?_____
Women: Do you have difficulty achieving orgasm?_____
Men: Do you have difficulty maintaining or achieving an erection or ejaculating?_____
Do you have any questions about your sexual functioning?_____
Is there anything about you or your partners sexual activity you would like to change?_____

Signature of person filing out form: _____Date:_____

Staff member: _____Date:_____

ADVANCED BENEFICIARY NOTICE

This notice is provided by Magic City Wellness Center as a courtesy to our patients that services and/or procedures that the providers feel are necessary may not be covered by your health insurance. The insurance company may decide these are not “medically necessary”.

The list is not generic for all insurance companies. What one insurance company may cover, another insurance company may not. The extent of coverage varies greatly from company to company, and sometimes even within the company.

All services or procedures ordered by your provider at Magic City Wellness Center are felt to be necessary. However, if your insurance company decides against payment, you or your responsible party will be held accountable for the unpaid amount.

By signing below, you have read and understand the above statements by Magic City Wellness Center. Also by signing you acknowledge your responsibility for payment to Magic City Wellness Center for any unpaid balance by your insurance company. This applies to each date of service.

Patient Name: (Please Print)_____

Patient/Guardian Signature:_____

PATIENT RECORD OF DISCLOSURE

This form is to provide Magic City Wellness Center with a HIPPA compliant listing of ways we may or may not contact you, who we can speak with regarding your care or ways of getting messages to you.

Home Number:_____
Cell Number:_____
Work Number:_____
Other Number:_____

May we leave a message at any of the above numbers?
(Check all that apply)Home:____Cell____Work____other____

Please list below any person with whom we may speak with or leave a message with regarding aspects related to your medical care.

Name:_____Relationship_____

Name:_____Relationship_____

Please note: Use of disclosures for emergencies may be permitted without prior consent.

Patient Name: (please print)_____

Patient/Guardian
Signature:_____

ACKNOWLEDGMENT FORM

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

SUMMARY:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). The Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information. I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information
3. The right to request that your information be restricted
4. The right to request confidential communication
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice

We want to assure you that your medical/protected health information is secure with us. The Notice contains information about how we will insure that your information remains private.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I further understand that the practice will offer me updates to the **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in any way.

Patient/Guardian Signature:_____ Date:_____

PAYMENT AGREEMENT

INSURANCE:
We currently accept most private insurance plans. Although we maintain computerized histories of payment by a given company, they do change. Therefore it is impossible to give a guaranteed quote at the time of service. We estimate your portion based on the most up to date information available at the time of service.

BILLING:
We base the patient payment on the required co-pay or percent the insurance company contracts you to pay up front. This is only an estimate. For example, there may be a deductible, or you may have received treatment in another office prior to joining our office. Insurance companies do not inform us of any changes in your benefits.

INSURANCE DID NOT PAY:
We bill your insurance company as a courtesy. All the claims not paid by your insurance are your responsibility. Medical insurance is a contract between the employer and the patient. It has no connection at all to us as your medical office. The extent of coverage varies greatly from company to company, sometimes even within the company. It has no effect on the level of service provided by Magic City Wellness Center or the fee charged for those services.

We request payment at the time the services are rendered. It is the patient's responsibility to obtain prior authorizations before services are rendered. We are unable to know if your plan covers a procedure until it is billed to them and we receive an explanation of benefits. It is the patient's responsibility to contact your insurance company for eligibility and coverage information.

We require payment in advance for immunizations because many private insurance companies do not cover these services.

50% any outstanding balance that is 120 days past due will be due BEFORE your next appointment. If that is not possible, then please contact MCWC, at mcwc@mcwc-bao.org to discuss a payment plan.

I have read, understand and accept terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of my treatment. I also understand that I will be responsible for any unpaid claims not made by my insurance provider.

Patient Name: (please print): _____

Patient/Guardian Signature:_____

Date:_____

DRUG/NARCOTICS POLICY

1. We will not refill medication that are lost, stolen or damaged in any way. All medications are controlled substances and it is your responsibility to take care of your medication.
2. Altering prescriptions is a felony. If you alter or forge or call in any prescriptions you will be prosecuted.
3. Chronic pain should rarely be treated with large amounts of narcotics. It is your responsibility to exercise self- control. If you feel your medication is not helping, or feel that you need something stronger or different, you must call and make an appointment to talk with a provider concerning your medications. No medications will be changed without a visit.
4. We will make sure that you have an appropriate supply of pain medications or controlled substances to treat your medical condition. We must be the only providers prescribing medications to you. We will not treat any patients who are currently receiving controlled substances from another provider. Non-compliance will result in a dismissal from MCWC.
5. Do not take any medications other than those prescribed to you by your provider. Do not give your medications to others.
6. If you fail to keep your follow-up appointments and you run out of your medications we will only call in enough to get you through to your appointment. This does not apply to controlled substances. If you fail to keep a make-up appointment after your medication has been called in we will not call in any additional medications. You must see the provider to get your controlled medications every 3 months.
7. We do not call in narcotic prescriptions on week-ends, holidays or after normal business hours.
8. Anyone receiving a prescription for a controlled substance will be subject to random drug screening.

I have read, understand and agree to this policy.

Patient Name (Print): _____

Patient/Guardian Signature: _____

Date:_____

OFFICE POLICIES

OFFICE HOURS:
Monday & Wednesday 8:00am-4:00pm, Tuesday and Thursday 10:00am-6:00pm, Friday 8:00am-12:00pm (closed 12:00pm-12:30pm, M-TR, lunch)

JUDGEMENT FREE POLICY:
Magic City Wellness Center is committed to treating every patient regardless of their sex, sexual orientation, gender identity, race, religion, ethnicity, creed, socioeconomic status, or family history with dignity and respect in a professional, welcoming and fun environment and with the highest quality of care available. Discrimination of ANY KIND is not tolerated at Magic City Wellness Center.

TIMELINESS:
Please make every effort to arrive 15 minutes early for your appointments. Patients arriving late cause the entire practice to run behind schedule. If you are more than 15 minutes late then your appointment will be cancelled and a new appointment must be scheduled.

CANCELLATIONS:
Appointments that are not cancelled at least 24 hours prior to the time of the appointment will cause a $30 late cancellation fee to be applied to your account.

WAITING ROOM:
Children may not be left unattended or with staff personnel while you are seeing the provider.

ACCEPTABLE FORMS OF PAYMENT:
Cash, Cred Card, and Checks (AMEX not accepted)

INSURANCE, CO-PAYS, and DEDUCTIBLES:
Deductibles, coinsurances and co-payments are due at the time of service.

PROOF OF INSURANCE AND COVERAGE CHANGES:
We must have a copy of your current insurance card. If you fail to provide us with the correct information in a timely manner, you will be responsible for the entire balance on your account. Most insurance companies will deny services after 90 days.

NON-COVERED SERVICES:
Some or perhaps all of your services may not be covered. If we do not receive partial or full payment from your insurance company, you are responsible for the balance.

OUTSTANDING BALANCE:
Balances not paid after 3 months will be referred to a collection agency. An outstanding balance is due before the patient can have another appointment at MCWC.

SELF-PAY:
Charges are due at the time of service.

LAB AND TEST RESULTS:
If you have any tests performed at our office, most results will be received in 7-10 business days. We will contact you with the results. Some results will require an office visit or referral. **The Lab Company is independent from this office. Please contact lab directly for any billing questions.**

SPECIALISTS/INSURANCE REFERRALS:
Referrals may take up to 7 business days to process. Under no circumstances will we back-date referrals or do non-emergent referrals for the same day. It is the patient's responsibility as the insured, to have your referral prior to your appointment with the specialist and to know your individual plan.

MEDICATION REFILLS:
Patient's name, date of birth, name of the drug and dosage, pharmacy name and telephone number are required to process a refill. Please, do not make multiple calls or inquiries about prescription refills as that will delay the process. An appointment may be necessary to review your medical history and make prescription changes. Medications that require prior authorization can take up to a week or more. Please exercise patience as we work to have your medication refilled with your pharmacy. **Refill requests are only processed during regular business hours. Refill requests received after 12pm (noon) will be processed the following business day.** Prescriptions for pain medications, controlled substances, and antibiotics will not be given after office hours. No exceptions. By law, pharmacists can provide a three-day refill supply of medication when the office is closed. ***Controlled Substances:*** *Your physician may refuse to issue a*

prescription, if in his/her estimation, there is concern the patient may be abusing or addicted to that drug. As a general rule, we only allow 3 months between visits before requiring an appointment in order to continue the medication. We reserve the right to deny refills based on suspected abuse, lack of appointments or other circumstances the office deems necessary. ***We reserve the right to deny refill requests should your account have an outstanding balance owed to MCWC. We can work with you on a payment plan if needed in order to bring your account current.***

PHONE CALLS DURING OFFICE HOURS:

Dial 911 in case of life threatening emergency. We encourage you to call with questions concerning your medical care. If you need to speak with your provider, leave a detailed message and a staff member will contact you within 1 business day (24 hours). Repeated calls move your message in our phone system to the back of the queue. Our providers are unable to practice medicine via telephone or email. Without an up to date office visit, it is impossible to correctly diagnose medical problems. Calls are returned in the order that their messages are received.

AFTER HOURS EMERGENCIES:

Call 911 in the case of a life threatening emergency. Refills, prior authorizations, and non-emergent questions will only be handled during regular business hours. Keep your phone line clear and disable the anonymous call block feature. Called in prescriptions require full name, date of birth, prescription details and pharmacy name and phone number. Providers are unable to retrieve pharmacy details after normal business hours.

PRACTICE DISMISSALS:

Occasionally, it is necessary to dismiss a patient from the practice and they will be asked to seek medical service elsewhere. Some reasons may include but not be limited to: multiple calls for non-emergency, noncompliance with recommended medical care, non-payment of bills, receiving controlled substances from multiple providers, threatening, abusive or rude behavior to staff or other patients. Magic City Wellness Center is an inclusive environment for all members of the LGBTQ community and its allies. Threatening or demeaning behavior towards other patients and staff is strictly forbidden and will not be tolerated. If any of these actions occur, you will be notified by certified mail that you have 30 days to find alternative medical care. During the 30 day period we will only treat you for an emergency.

CONCERNS AND COMPLAINTS:

Magic City Wellness Center is committed to ensuring EVERY patient regardless of sex, sexual orientation, sexual identity, family history, race, ethnicity, or socioeconomic status is treated fairly, equally and with the highest standard of care. If you ever encounter a situation that makes you feel uncomfortable please let the Director know as soon as possible so that they may document, address, and correct the concern. Our patients are our biggest asset and we want to ensure that you have a pleasant, friendly, welcoming, and comfortable visit every time.

FORM COMPLETION:

Completion of forms is time consuming and can be frustrating for both patients and staff. Allow at least one week to have your forms completed. A $10 fee per page is due on all forms that require staff review or signature. Rushed forms needed in less than 5 days require $20 per page processing.

I have read the above office policies. I understand them and agree to them as condition for being seen by a provider at Magic City Wellness Center.

Patient Name (please print):_____

Patient Signature:_____

Date:_____

Ask us about Avita Pharmacy ***or*** confirm which Walgreens you would like MCWC to send your prescription to:

Please put an "x" next to your Walgreens:

101 Greensprings Hwy ___	2101 Richard Arrington Jr Blvd ___
1560 Montclair Road ___	4496 Valleydale Rd ___
668 Lombe Ave SW ___	4700 Highway 280 ___
9325 Parkway East ___	1801 Montgomery Highway ___
3020 Clairmont Ave South ___	1150 N Fifth Street ___
3686 Grandview Pkwy, #120 ___	

Magic City Wellness Center is partnering with Avita Pharmacy and several local Walgreens to better help our neighbors who cannot afford expensive but necessary medications. Every eligible prescription filled at one of the above Walgreens, using your insurance, allows us to serve a patient with limited insurance coverage at no cost.

There is absolutely NO requirement to take your prescription to a Walgreens or Avita Pharmacy. If you use a pharmacy that is not Walgreens or Avita, then please let us know what your pharmacy is so we can better assist you in the future:

Pharmacy Name:_____

Pharmacy Address:_____
_____

Pharmacy Phone Number:_____

Patient (please print):_____
Patient/Guardian Signature:_____
Date:_____