Magnolia
Med Spa and Wellness Center

Patient Intake Form

PLEASE PRINT CLEARLY Today's Date _____

PERSONAL INFORMATION

PATIENT (S)_____ **RESPONSIBLE PARTY (if different)** _____

Date of Birth_____ Gender _____

Address_____ Address (if different) _____

_____ _____

City, State_____Zip_____ City, State_____Zip_____

Home Phone_____ Home Phone (if different) _____

Work Phone_____ Work Phone (if different) _____

Cell Phone_____ Cell Phone (if different) _____

Please indicate with an * which phone numbers we may NOT leave a message.

Patients' relationship to Responsible Party (check one): Self_____Spouse____Child_____Other _____

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Relative or friend in case of emergency _____
Name Phone # Relationship

Source of referral_____Reason for referral _____

How did you hear about Magnolia Med Spa and Wellness Center?_____

FINANCIAL

I understand that Magnolia Med Spa and Wellness Center does not accept insurance. Upon request, I will be given a receipt that I may submit to my insurance for possible reimbursement. As well, I understand that if I cancel within 24 hours or do not show up for an appointment I will be billed the entire amount of the appointment. I have been given the opportunity to ask questions regarding this statement.

_____
Signature of Responsible Party

_____
Printed Name

Date: _____

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Practice Policies

You will be evaluated by a trained and licensed provider. We wish to take this opportunity to welcome you and also to state some basic principles we believe essential in establishing a good relationship between us. Please read through this information, asking questions as needed.

1. INITIAL INTERVIEW: Your first history and physical is considered an evaluation interview and exam. At the time of this appointment, the following decisions will be made with you:
   a) If you meet the requirements for the infusion and is it an appropriate treatment option
   b) Frequency of infusion sessions
   c)Goals of therapy (what you hope to gain from this process.)

2. APPOINTMENTS: Each appointment varies in length depending on your chief complaint. Typically, 40 min infusion appointments take just under 2 hours, 4 hour infusions are typically around 5 hours in length. At the end of each appointment you can make arrangements for your next appointment or you may also book all your prescribed appointments at once.

3. CANCELLATIONS: If you find that you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list. You will be personally charged for your appointment if not canceled at least 24 hours in advance.

4. PAYMENTS: We would greatly appreciate payment in full prior to the start of your appointment. We accept cash, Venmo and checks. Please make checks out to “Magnolia Med Spa and Wellness Center”.

5. INSURANCE: Insurance is an agreement between you and your insurance company as to how treatment will be paid for.
   We do not directly participate with insurance plans. However, we will assist you by giving you receipts to submit. Some insurance companies will pay for a portion of outpatient infusion services. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. We will be happy to assist you in filling an insurance form if you feel there is a chance your insurance company will pay for these services. The hourly rate will apply. Payments for services received through Magnolia Med Spa and Wellness Center are ultimately your responsibility. If your insurance company requires that outpatient infusion services be preauthorized,

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it is your responsibility to initiate the preauthorization process, i.e. contacting your primary care physician, insurance company, or a third party "gatekeeper". Failure to obtain required preauthorization for outpatient services will result in you being held 100% responsible for all charges.

6. CONFIDENTIALITY: All information regarding the specific nature of your treatment is maintained at Magnolia Med Spa and Wellness Center and is considered confidential within the office unless specified by you in writing. However, each provider at this office reserves the right to use specialty consultation with other medical providers at the office as deemed necessary. We follow HIPAA and maintain confidentiality.

Please initial boxes

_____Yes _____No I acknowledge that I have read and understand all of the foregoing statements and that my signature indicates that I agree to abide by all of the above conditions.

_____Yes _____No I have received a copy of the Privacy Practices Form.

_____Yes _____No I consent to the exchange of treatment information between Magnolia Med Spa and Wellness Center and my primary care provider and/or mental health provider.

Patient(s) signature/initials: _____

Provider Signature _____

Office and Phone Number____25_TLD CIRCLE_Port Matilda, PA 16870_____1-814-404-2726_____

Nurse signature:_____ Date: _____