MAGIC CITY Wellness Center
A BAO Affiliated Program

Medical Record # (office use only)

Client Registration

Legal Name: Last First Middle Initial

Name you would like to be called:

Sex assigned at birth: (please check one)* ____Female ____Male

*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 you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence.

Pronouns:_____

Date of Birth: M_____/D_____/Y_____ SSN:_____ State ID/License_____

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone:_(____)_____Cell Phone:__(_____)_____Work Phone:__(____)_____

OK to leave voicemail?__Y__N OK to leave voicemail?__Y__N OK to leave voicemail?__Y__N

Best number to use? Home_____Work_____Cell_____

Local Address:

_____City:_____State:_____Zip:_____

Billing Address: (if different from above)

_____City:_____State:_____Zip:_____

Email Address:

Occupation: Employer/School Name: Are you covered under school or employers insurance?

Emergency Contact

Name:_____Phone:_____Relationship:_____

Who should we **NOT** contact:

_____

Parent/Guardian Name:_____Phone:_____Relationship:_____

Magic City Wellness Center will send certain correspondence, such as bills, to your mailing address. How would you prefer to receive other types of written correspondence? (check one): Letter/Mail:_____Email:_____Other:_____

This information is for demographic purposes only and will not affect your care.

Annual Income: _____ **How many people does your income support**?_____

Employment Status: Full Time ___ Part Time___ FT Student___ PT Student___ Retired___ Unemployed___ Other___

Race: African American/Black___ Asian ___Caucasian ___Multiracial ___Native American ___Pacific Islander ___Other___

Ethnicity: Hispanic/Latino/Latina____ Not Hispanic/Latino/Latina____ Country of Birth: USA _____Other_____

Preferred Language (choose one) English_____Espanol_____French_____Portugues_____Other_____

Do you think of yourself as: Lesbian, Gay, Homosexual ___Straight or Heterosexual ___Bisexual ___Other ___Don't Know____

Marital Status: Married ___Partnered ___ Single___ Divorced ___ Other ___ **Veteran Status**: Veteran ___ Not a Veteran___

Referral Source: Self ___ Friend or Family ___ Health Provider ___ Emergency Room ___ Ad/Internet/Media ___ Other ___

What is your Gender Identity? Female _____ Male _____ Genderqueer or not exclusively Male or Female _____

Do you identify as transgender? Yes __ No __ Other_____ ___

What Services are you interested in?_____

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Consent for Treatment

Patient Name: _____Date:_____

Time:_____(A.M./P.M.)

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 thought 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, Payment 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. Financial assistance is available for those who qualify.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serve 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 in any way 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 Patient Rights and Responsibilities.

Patient Signature:_____Date:_____

Witness:_____Date:_____

General Information: Informed consent will be obtained from all patients accessing medical, mental health, and/or research services/activities. Informed consent is not merely a signed document. It is an ongoing process that considers patient needs and preferences, compliance with law and regulation, and patient education.

The patient and/or family, as appropriate, are given information about;

- The patient's condition
- Proposed treatments, procedures, or research activities
- Potential benefits and drawbacks or proposed treatments or procedures
- Problems related to recuperation
- Alternative treatments or procedures
- The provider performing procedures or treatment; and
- Any business relationships among individuals treating the patient, or between the organization and any other health facility.

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PATIENT MEDICAL INFORMATION

Name: _____ **Preferred Name:**_____

Date of Birth: _____

Personal Medical Information: Are you being treated for any of the following medical conditions? (Check 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:_____

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MEDICAL RECORDS REQUEST

Patient Name:_____Date of Birth:_____

Telephone Number:_____Alternate Number:_____

Release to: Magic City Wellness Center
2500 4th Avenue South
Birmingham, AL 35233
Phone: 205.877.8677 Fax: 205.877.8675

Release from: Physicians Name:_____

Address:_____

Phone:_____Fax:_____

The information being disclosed is for the purpose of continuing health care.

Please fax the information accordingly: healthcare covering the following period(s):
____ALL____from_____/_____/_____ to _____/_____/_____

I understand the specific information to be released may include alcohol or drug abuse, mental health or HIV status. _____(Initial Here)

Unless otherwise indicated, this authorization will expire one(1) year from the date of signature. The health care provider and employees are released from any legal responsibility or liability for the health care of the above information to the extent indicated or authorized herein. I understand that this authorization may be revoked in writing at any time, except to the extent for the action has been taken in reliance on this authorization for the purpose stated above.

Signature of patient or legal guardian_____

Relationship to patient:_____

Date:_____

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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 or Legal Representative Date

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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 may 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.**
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.**
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. If you fail to keep a make-up appointment after your medication has been called in we will not call in any additional pain medications. You must see the provider to get your medications if you have missed two appointments.**
7. **We do not call in narcotic prescriptions on week-ends, holidays or after normal business hours.**

I have read, understand and agree to this policy.

Patient Name (Print): _____

Patient/Guardian Signature: _____Date:_____

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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: Uses disclosures for emergencies may be permitted without prior consent.
Patient Name: (please print)_____

Patient/Guardian Signature:_____

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CREDIT AND DEBIT CARD AUTHORIZATION

First Name:_____Last Name:_____Middle Initial:_____

Preferred Name or Pronouns:_____

Street Address:_____

City:_____State:_____Zip:_____

Name as it appears on card:_____

Credit Card #:_____

Debit Card #:_____

Expiration Date:_____3 or 4 CVC#_____

Due to economic conditions and problems receiving payments from insurance companies and sometimes patients, Magic City Wellness Center must have either a credit card or debit card as back up payment. This information will remain in your file and be kept confidential. This form of payment will be used in the following events: No-Show Appointment Fee, Co-Pays missed at time of visit, Co-Insurance, Balances Owed, Deductible or Insufficient Funds on a check received. Should you owe a balance above $40 in Co-Insurance or Deductible, we will notify you about the payment being charged to your card. Checks returned will additionally incur a $30 fee.

Patient Signature:_____

Staff Signature:_____

Date:_____

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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 use 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.

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:_____