Thank you for choosing our office – we'll do our very best to provide quality healthcare to you, your friends and family members, because we love to grow by referrals – you've joined our healthcare family and we do consider it to be a family.

First Name: _____ Middle Name: _____ Last Name: _____

Street Address: _____

City, State, ZIP: _____

PO Box Address (if you have, we need both) _____

Home Phone #_____ Work #_____ Cell phone #_____

What # should we call first? _____ Social Security #_____ Date of Birth _____

Marital Status: Single Married Committed Relationship Engaged Needs Work Happy Separated Divorced Widowed

E-MAIL address _____ How did you hear about us? _____

Employer Name & Address: _____

Emergency Contact: NAME & Relationship _____ Phone #_____

Who else can we call? NAME & Relationship: _____ Phone #_____

→ Can we leave your **LAB RESULTS** on your answering machine? (**Circle**) YES NO Only if they are normal

→ **WHO** are we **AUTHORIZED to SPEAK** to regarding your labs and medical information: No one but me

Name(s)_____ **Relation**? _____

I AUTHORIZE MFM to communicate with other healthcare providers about my care: (**Circle**) YES NO **Your Initials**_____

IF PATIENT IS A MINOR *- Parents are married Separated Divorced Primary custodian:*_____

Parent/ Guardian _____
Name Address Phone #

Parent/ Guardian: _____
Name Address Phone #

Who is authorized to bring the child to the doctor? _____

If child is under 18, do you authorize treatment without your presence in the room? YES NO Guardian Initial _____

BILLING POLICIES – READ THIS CAREFULLY – YOU'LL WANT TO KNOW

Missed appointments / Late Cancellations Often, we have to turn patients away who need medical attention; therefore, in fairness, a ***$25 fee*** will apply if you do not give us **24 hours notice** – this includes SAME DAY Cancels/Reschedules.
A ***$50 fee*** applies for double appointments and multiple cancellations ex: Health Assessments, procedures.
Fee for service This covers the time you spend with Dr. Gutsin, but it also takes into account the complexity of your medical conditions, as well as reviewing and potentially changing your medical regimen, writing prescriptions, ordering and reviewing your labs, arranging and managing care coordination with other physicians if necessary, reviewing x rays, prior authorizations, documentation done by the nurse and physician, etc. There's a lot that goes on behind the scenes.
After Hour Phone Calls If a medical issue needs to be handled over the phone, you or your Insurance company may be billed.
Returned Check Fees If your check is dishonored, you'll be charged a $35 fee and will be required to pay by cash or CC in future
Form Charges Additional fees ($20 - $50) apply for all FMLA, Work and other forms that may not be listed here.
Mail Charges Due to rising costs, unfortunately, a $1.00 fee will be assessed for mailing labs, reports, and paperwork, etc
Administrative Fees You may be responsible to pay a $10 admin fee if you do not present the correct information (insurance, prescription coverage, etc) at the time of service.

Magnolia Family Medicine ~ Richard A. Gutsin, D.O. Phone: 910-796-3212 Fax : 910-796-3216 **TODAY'S DATE**: _____→

THE FINANCIAL STUFF: All co-payments, deductibles etc are due AT THE TIME OF SERVICE – THAT MEANS TODAY!
We file insurance on your behalf. If we do not participate, payment is due in full today and we will still file for you if able.
We have copies of insurance company fee schedules, so we know what we are allowed to collect. If your insurance company says you owe more than we collected, we'll send you the bill. We take credit cards over the phone, or you can mail in a check. Payment is due when you are notified. If you have any questions or problems – **PLEASE ASK NOW**!

CIRCLE YOUR INSURANCE – YOU MAY HAVE MORE THAN ONE: BCBS NC BCBS OUT OF STATE PPC CIGNA PHCS
MEDCOST UNITED HEALTHCARE TRICARE PRIME/STANDARD HUMANA MEDICARE ADVANTAGE:_____
AETNA MEDICARE MEDICAID SECONDARY: _____ OTHER: _____
We file to primary & secondary ins only. We provide the papers you need to file to your tertiary ins. (3rd) for reimbursement.

POLICY HOLDER INFORMATION - *No need to complete if YOU are the policy holder.* **SIGNATURE STILL REQUIRED.**

CIRCLE RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER/Specify _____
INSURED INFO: First Name_____ Middle Name_____ Last Name_____
Their birthday: _____ Social Security # of insured: _____ Their phone #:_____
Their Race: Caucasian Black Asian Other _____ Their Ethnicity: Hispanic Non-Hispanic Decline
Street Address: _____ City, State, ZIP: _____
If known, Employer name & address of policy holder: _____ Phone #:_____

I KNOW IT'S MY RESPONSBILITY TO INFORM THE STAFF OF ANY INSURANCE CHANGES AND WILL DO SO IMMEDIATELY.

SIGNATURE OF PATIENT (that's you) _____ **Date**_____

***** ALL PATIENTS NEED TO COMPLETE SECTION BELOW IN CASE YOUR INSURANCE STATUS CHANGES -- LOSE OR OBTAIN *****

↙ PLEASE INITIAL THAT YOU UNDERSTAND AND AGREE TO *ALL* THESE POLICIES:

→_____ *As a Self Pay Patient, I agree to pay ALL charges in full at the time of service and will not accrue a balance due.*

→_____ *Balances NOT paid by insurance or that are assigned by your insurance company to you –YOU OWE.*
Contact your insurance company to verify your medical benefits, co-pays, deductibles, etc, to prevent any surprise bills.

→_____ *I understand my PAYMENT IS DUE UPON NOTIFICATION* - the service has already been provided. You've signed a contract with your insurance company stating that you will pay. We've signed one saying that we accept your plan and will collect payment when assigned to you. We won't break our contract – period.

SIGNATURE ON FILE - Signature indicates that you have reviewed and approve of the following written policies:
I authorize Magnolia Family Medicine to file all insurance submissions on my behalf.
I authorize payment to be made from my insurance company directly to Magnolia Family Medicine.
I authorize release of my billing and medical information to my insurance carrier at my or their request.
I authorize Dr. Gutsin and his staff to act as my agent in helping to obtain payment from my insurance company.
I understand that ULTIMATELY, I AM RESPONSIBLE FOR MY BILLS AND WILL PAY UPON NOTIFICATION.
I understand that if I wind up not having insurance (despite the fact I think I do) I will still pay my bill by cash or CC.

SIGNATURE OF PATIENT/ RESPONSIBLE PARTY: _____

Print name _____ Today's Date_____