MAGNOLIA
PREMIER HEALTH
CONCIERGE MEDICINE
JAMIE CAUDILL, M.D.
LYN DIEFENDERFER, M.D.

New Patient Information

Date:_____ Contact Preference: ❑ Home ❑ Mobile ❑ Text ❑ Email

Patient's Name:_____

Date of Birth:_____ Sex:_____

Current Address:_____

Home Telephone Number:_____ Mobile Number:_____

Email Address:_____

Marital Status:_____ Spouse's Name:_____

SSN:_____

Patient's Employer:_____

Current/Previous PCP:_____

Preferred Pharmacy:_____

Emergency Contact Information:

Emergency Contact Person:_____

Telephone:_____ Relationship:_____

Is This Person a Power of Attorney and/or Healthcare Surrogate? ❑ Yes ❑ No

Insurance Information:

Primary Insurance:_____ Phone:_____

ID/Member No:_____ Group:_____

Secondary Insurance:_____ Phone:_____

ID/Member No:_____ Group:_____

Authorization to Share Medical Information:

I authorize Magnolia Premier Health to use and disclose a copy of health & medical information to the following:

Name of Person Authorized to Receive Information:_____

Phone:_____ Relationship:_____

❑ I authorize Magnolia Premier Health to leave messages on my voicemail/answering machine such as test results and/or messages that may contain personal information.

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Insurance and Financial Agreement

Assignment of Benefit | Patient Responsibility

Authorization To Bill And Release Medical Information

I authorize the submission of claims(s) for payment to Medicare, Medicaid or any other payor for any services provided to me by Magnolia Premier Health. I authorize the release of any information acquired during my treatment to my insurance company. I understand that I am financially responsible for the services and supplies provided to me by Magnolia Premier Health regardless of my insurance coverage and, in some cases, may be responsible for an amount in addition to that which was paid by my insurance (i.e. copays and deductibles). I request that payment of authorized benefits be made either to me or on my behalf for any services received. I agree to immediately remit to Magnolia Premier Health any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Magnolia Premier Health. I authorize Magnolia Premier Health to appeal payment denials or other adverse decisions on my behalf. I authorize any holder of medical information or other relevant information about me to release such information to Magnolia Premier Health, its billing agents, the Centers for Medicare and Medicaid Services and/or any other payors or insurers and their respective agents or contractors as may be necessary to determine benefits payable for any services provided to me by Magnolia Premier Health.

Insurance Pre-Certification

I understand that I am responsible for any required notification needed by my insurance company in order to pay for services rendered. If this is not completed, my benefits may be reduced and I am responsible for all non-covered charges.

Financial Agreement

The undersigned guarantees prompt payment of all charges for services rendered at time of service. Any unpaid balance due by patient beyond 30 days may be turned over for collection.

Consent for Medical Services

I consent to treatment, diagnostic, and/or therapeutic services as ordered and/or provided by Magnolia Premier Health

Cancellation Policy

I understand there is a 24-hour notice to cancel an appointment and that I may be charged for canceling an appointment without notice.

The undersigned certifies that he/she has read and understands the above and fully accepts all specified terms therein.

Name:_____ Date of Birth:_____

Signature:_____ Date:_____