Thank You For Choosing

MAGNOLIA MEDICAL GROUP

2925 E. Colfax Avenue

Denver, CO 80206 P: 303-209-5115

Welcome to Magnolia Medical Group!

In order to serve you better, we would like to provide you with important information regarding your treatment. Please read each of the below statements carefully and thoroughly and sign where indicated to acknowledge you understand and agree to the terms outlined in this agreement. If you have any questions or concerns, please discuss these with your provider and/or counselor.

General Information

Magnolia Medical Group complies with all federal and state laws in regards to patient consent where applicable. Services provided by Magnolia Medical Group are for the intended purpose of opioid and alcohol dependency only. Administrative hours are Monday through Friday 8:00 am to 5:00 pm. (Subject to change) Our website www.magnolia-medical.com contains more detailed information about our philosophy.

Emergency Information

Should an emergency arise, please call 9-1-1. For non-emergency service after hours a message can be left at 303-209-5115. Please note all calls are recorded and logged for quality purposes.

Program Information

Attending our outpatient Suboxone program requires your commitment. Your adherence to schedule, rules, and instructions from Magnolia Medical Group; as well as, being present and participating in the program is very important for your recovery process. It is also an opportunity for you to give yourself permission to receive help and experience a healthy community with others. Patients should expect to participate in this program for a minimum of one year.

Patients who enroll in Magnolia Medical's treatment program will meet with a physician to provide medication therapy and are required to attend 6 individual therapy sessions. This treatment program is individualized and scheduled according to your physician's analysis of your needs as well as compliance with therapy, drug screening, and absence of any behavioral issues. Patients may be chosen at random for an "observed" drug screen and/or random pill/strip count at any given time. Magnolia Medical's program is based on an underlying principle of deep respect for each client who seeks treatment, with the expectation that our clients will behave in a respectful manner to clinical and administrative staff. **No form of verbal and/or physical abuse will be tolerated!**

Patient Signature______________________________________

Patient Demographic Form

Today's Date: ____

Name (Last, First, Middle Initial) ____

Address/Apartment Number:

____

City/State/Zip Code :

____

Phone Number/Area Code:

____

Date of Birth (Month/Day/Year): __________/_________/________

Social Security #: ______________

Sex : ( ) Male ( ) Female Race: _______________

Race: ( ) Black-Non Hispanic ( ) American Indian/Alaskan Native ( ) Hispanic

( ) Asian/Pacific Islander ( ) White-Non Hispanic ( ) Other

Email: ______________________________

Do you currently have Medicaid? ( ) Yes ( ) No Are you a Veteran? ( ) Yes ( ) No Do you have a valid driver's License? ( ) Yes ( ) No Mode of Transportation?_________

Insurance Information

Name of Insurance Company: ____

Policy and Group Number: ____

Subscriber Name: _______________________ Date of Birth: __________________________

Relationship: ____

Subscriber Address: ____

Subscriber phone number: ____

Patient Intake Form

Psychological

Marital Status: ( ) Married ( ) Never Married ( ) Single ( ) Separated ( ) Divorced ( ) Other

Religious Preference : ( ) Catholic ( ) Christian ( ) Baptist ( ) Jewish ( ) Jehovah's Witness

( ) Other

Sexual Orientation:( ) Heterosexual ( ) Bisexual ( ) Gay ( ) Lesbian ( ) Transsexual

( ) Do not wish to disclose

Social Preference/Living Arrangements

Number of people in your household: ___ Do you: ( ) Live alone ( ) Live w/others

( ) Live w/spouse/kids

( ) Live w/children ( ) Other:

____

Employment

( ) Employed Full Time ( ) Employed Part Time

Length of employment: ____

( ) Unemployed ( ) Disabled ( ) Retired

( ) Other: ____

Education

Highest Grade in School Completed: _________________

Degree Earned: ________________________

Legal Status

( ) No legal problems ( ) Under Parole Supervision ( ) On probation ( ) Case Pending

Have you ever been arrested for a drug related charge? ( ) Yes ( ) No

Do you have any court dates pending? ( ) Yes ( ) No If yes, when is your court date?

____

Current Drug Use

( ) Heroin ( ) Alcohol ( ) Barbiturates ( ) Other Sedatives or Hypnotics ( ) Methamphetamine

( ) Amphetamines ( ) Cocaine/Crack ( ) Marijuana/Hashish ( ) PCP ( ) Vicodin ( ) OxyContin

( ) Percocet ( ) Other-please specify:

____

Opiate Drug Use

Date of last use: __________ Average daily amount: ____________ Length of use:

____

Usual routine of admission: ( ) Oral ( ) Smoking ( ) Inhalation ( ) Injection

Drug Treatment History

Date of last admission: ___________ Date of last discharge: _________

Number of admissions: _______

What was the type of treatment during your last admission? ( ) Detox ( ) MMTP

( ) Outpatient

Outcome of last admission treatment was: ( ) Completed ( ) Not Completed Are

you currently transferring from another methadone program? ( ) Yes ( ) No

Medical History

Please list all past and current medical conditions:

____

____

Please list all past and current surgical history:

____

Any Family History of Drug Addiction? ( ) Yes ( ) No If yes, please specify:

____

Any Family History of Alcohol Addiction? ( ) Yes ( ) No If yes, please specify:

____

Any Drug Allergies? ( ) Yes ( ) No If yes, please specify:

____

Please list current medications you are taking:

____

____

Emergency Contact

Name:____

Relationship:___________________________ Phone Number:__________________________

I have read this document and completed to the best of my ability!

Patient Signature: ____

Witness Signature: ____

By signing and initialing this form, I understand the following:

❏ _____________ I agree that in order for the physician to prescribe Suboxone/ Buprenorphine, they must access the Colorado PDMP report. I give consent for the physician to access my CO. PDMP report as often as appropriate.

❏ ____________ I agree that I am financially responsible for the payment of the services rendered and all payments, copays, and no show fees are due at the time of service.

❏ ____________ I agree that treatment with an addiction counselor is required for the Suboxone program. Not complying with the counseling services can lead to dismissal from the program.

❏ ____________ I agree that group members names, comments, and discussions that occur within the group are confidential.

❏ ____________ I agree to Magnolia Medical's attendance policy and understand the commitment and dedication to the program is my responsibility. My negligence and non-compliance may result in termination from the program.

❏ _____________ I agree to the patient responsibility for controlled substance form. I acknowledge that my non-compliance may result in termination from the program.

❏ ____________ I agree to cooperate with the urine drug testing and random pill/strip counts.

❏ ____________ I agree I must sign a HIPAA release of information before anything pertaining to my treatment and/or care will be disclosed.

❏ ____________ I understand my HIPAA rights and I authorize Magnolia Medical to leave a message, including those containing to PHI, for me at the number and/or email provided. **I have read and understand all the information provided by Magnolia Medical Group. I wish to be treated with buprenorphine/Suboxone.**

Patient Signature: ____ Date: _________________

Privacy Pledge

Magnolia Medical Group will not disclose any client information without a HIPAA authorization form. (Upon request Only) Except in circumstances pertaining to Colorado legal statutes that allow healthcare professionals to break confidentiality without consent. Circumstances such as a client may be in serious danger in which they may cause harm to themselves and/or others, any suspicion of child or elder abuse and rare cases of a court subpoena. You may request to review your records by submitting a written request to our medical staff. All medical records requests to outside agencies the client must provide a signed HIPAA release and allow up to 30 days to process. Patient's requesting their medical records to be released to them directly may be subjected to a fee. (Please see the medical staff for pricing information)

Attendance Information

Participation in the program requires a commitment to being on time and present for every appointment. Patients who miss appointments may be discharged from the program or may require more medical and therapeutic supervision. If you are unable to consistently attend the program and have multiple unexcused absences, this may be an indication of your needing a higher level of care.

If you are unable to attend your scheduled appointment, please call 303-209-5115 at least 24 hours in advance to reschedule. Patients more than 15 minutes late to an appointment may have to be rescheduled for a different time/day. More than three no-shows in a 60-day period will result in a 60-day temporary termination from the program.

If an emergency occurs outside of program hours, such as you are feeling suicidal and you are not able to follow your safety plan, go to the nearest emergency room for a psychiatric evaluation and/or dial 911. If we do not hear from you, a Magnolia staff member will call to assess how you are. If we are not able to get in contact with you, a staff member may speak with the individual designated under your emergency contact.

Patients are responsible for self-administration of their medication. If you have questions and/or concerns with your medication, please inform your physician.

Patient Signature______________________________________

Patient Financial Responsibility

For Patient with health insurance:

I understand and agree that I'm financially responsible for all charges for any and all service rendered. This includes any medical services or visit, counseling, lab charges or any other screening ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the service I receive.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physicians and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services that I will be financially responsible for all services rendered.

Magnolia Medical Group can NOT waive copays, deductibles, co-insurance, or non-covered service amount defined as patient responsibility under the terms of our contract with the health insurance.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

For patients with no insurance (self-pay):

The below fees cover all doctor visits, counselor visits and drug screens. All fee and copays are due at the time of service and can be paid by cash or credit cards.

Not covered under fees below are medications, psychiatric visits, flu shots and DNA swab.

1) Phase 1= $908.00
2) Phase 2= $804.00
3) Phase 3= $500.00

Signature of Patient/Responsible Party ___________________________________

Date________________

In addition to phone calls, give Magnolia Medical permission to contact me in the following ways regarding reminders for my future appointments:

____ Text

____ Email

I understand that I must provide up-to-date information (i.e., phone number/email address) in order to receive these reminders.
I also understand that I have the right to revoke this permission at any time (see below).

____ ___________________ (Print Name) (Date)

____
(Signature)

I revoke the above permission(s):

____ Text

____ Phone Call

____ Email

____ ___________________ (Print Name) (Date)

____(Signature)

Accessing the CO PDMP

The Colorado prescription drug monitoring program (CO PDMP) is an electronic service providing patient information in regards to their controlled substance prescriptions that have been filled in the past 2 years. It is required by law that before a physician writes a prescription for a controlled substance that they review the patient's CO PDMP. Suboxone is a controlled substance and therefore accessing your CO PDMP record is essential to ensure patient safety and compliance with rules of Magnolia Medical's treatment program.

Counseling Services

Magnolia Medical Group offers individual counseling services conducted by our licensed addiction counselors. This service requires participation from the patient in order to maintain a stable treatment plan. Counseling appointments may contain private medical and psychological information that can be distressing and difficult

Patient Signature______________________________________

1. **Consent:** I voluntarily consent to this admission to the Facility and do hereby voluntarily consent to such care-encompassing procedures and treatment by the Facility that its Director, employees, and designees deem necessary in their judgment. These services may be terminated by me at any time I so desire by informing the Facility verbally or in writing. I understand that any evaluation, testing, counseling/therapy or other treatment procedure is confidential and will not be released by the Facility without my written consent.
2. **Emergency Treatment and/or Hospital Transfer:** I understand while at the Facility, the need for emergency treatment and/or transfer to a hospital may become necessary and appropriate. Should the need for such treatment and/or transfer be deemed necessary and appropriate due to an emergency, by attending physician, their assistants and designees, I consent to such emergency treatment and/or transfer to a hospital and indemnify the Facility and its staff, or any physician who may be in attendance, from any loss resulting from such emergency treatment and/or transfer.
3. **Medical Consent:** The Patient is under the care of their attending physician, or the physician assigned by the Facility and the undersigned consents to examination and laboratory procedures. Medical treatment is rendered under the order of the physician or his/her designee.
4. **Drug Screen Consent:** I further understand that part of the treatment offered by the Facility may require my submitting to urinalysis for drug/alcohol content, psychological testing and other such similar procedures and that the consent that I have given in this document shall include, but not limited to, the same. The results of urinalysis will be released without Patient consent. Federal regulations prohibit making any further disclosure of this information unless expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by CFR 42, part 2.
5. **Conditions of Treatment:** I acknowledge and understand that no promises or guarantees have been made to me regarding the final outcome of my treatment by the Facility and I do hereby absolve the Facility from any liability in the event its treatment of my person is unsuccessful either in the short or long term.
6. **Rules and Regulations:** I hereby agree to comply with and abide by the policies, rules and regulations of the Facility during my treatment stay.
7. **Releases of Information:** The Facility may disclose all or any part of the Patient's record to any person or corporation which is or may be liable under a contract to the facility, or the Patient, or to a family member of the Patient, all or part of the facility charges. The Facility may further disclose all or said part of the Patient's record to the referring doctor, hospital, clinic, and in case of minors, may disclose aftercare forms to the Patient's school system. A Release of Information form may be required for third parties.
8. **Personal Valuables:** The Facility shall not be liable for the loss or damage to any money, jewelry, eyeglasses/contact lenses, dentures, documents or other articles of value.
9. **Drugs:** The Patient shall neither use, nor keep, any drugs or drug paraphernalia as not permitted by or on behalf of the attending physician. All medications should be taken as prescribed by the physician during the Patient's stay at the Facility. Any such contraband found in the Patient's possession will be removed and destroyed.
10. **Injury:** In consideration of the acceptance of the undersigned for voluntary care by the

Facility, I do hereby waive, release and indemnify the facility, its officers, agents, employees and professional associates of all any kind of liability (legal, financial, medical, and otherwise) for any claim of loss or damages because of any injuries, direct or indirect which may occur to me or to my family or friends, or for loss, damage or theft of any of my personal property during my enrollment, whether or not the professional associates, and whether or not such injury, loss or damage occurs on or off the premises or in or out of a vehicle, surveillance or supervision of the facility or its officers, agents, employees or professional associates.

The undersigned certifies to understand and agree to the above, receiving a copy thereof, and is the Patient, or is duly authorized by and on behalf of the Patient to execute the above and accept its terms personally and upon the Patient's behalf.

Patient Signature______________________________________

Confidentiality, HIPAA, and Privacy Practice Notice

THIS NOTICE DESCRIBES HOW MEDICAL AND ALCOHOL AND DRUG RELATED

INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

General Information:

Information regarding your health care, including payment for health care, is protected by two federal laws: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) 42 USC 1320d et seq., 45 CFR parts 160 & 164 and the Confidentiality Law, 42 USC 290dd-2, 42CFR Part 2.

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal laws and regulations. Generally, the program and patient may not say to a person outside the program that a patient attends the program nor disclose any information identifying a patient as an alcohol or drug abuser and/or identifying a patient's health status unless:

- A patient consents in writing.
- The disclosure is allowed by a court order.
- The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Treatment, payment and health care operations:

The Facility uses and discloses your protected health information for treatment, payment, and health care operations. Some examples of when our office may use or disclose your health care information for these purposes include:

● Sharing test results with other health care providers for confirmation of a diagnosis; ● Providing your diagnosis or other information about your health to your insurance provider or our billing service to obtain payment for the health care services we provide; ● **Reviewing information as part of our quality improvement program. Other uses and disclosures:**

The Facility may also use or disclose your protected health information, in compliance with the guidelines outlined by law, for the following purposes:

- Providing you with information related to your health;

- Contacting you regarding appointments, information about treatment alternatives, or other health related services;

● Incidental uses or disclosures (e.g., listing your name on a sign-in sheet, etc.); ● Compliance with all laws (including reports of suspected abuse, neglect or violence); ● Providing certain specified information to law enforcement or correctional institutions; ● Providing information to a coroner, medical examiner, funeral director or organ procurement organization;

- Public health activities when requested by a public health authority or the FDA. Responding to health oversight agencies;
- Responding to court or administrative tribunal orders, subpoenas, discovery requests or other lawful process;
- Research activities;
- When necessary to avert a serious threat to health, safety, or when Patient is a danger to themselves;
- Military affairs, veterans affairs, national security, intelligence, Department of State, or presidential protective service activities;
- Providing information to public or private disaster relief agencies; or Information to a family member, other relative, or close personal friend when: notification of your location, general condition or death; to assist in your health care (e.g. pick-up prescriptions or other documents, note follow-up care instructions, etc.)

Authorization for other uses:

The Facility will make other uses and disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at any time, by notifying us in writing that you wish to revoke your authorization.

Your rights regarding the privacy of your health information:

Subject to limitations outlined by law, you have certain rights related to use and disclosure of your protected health information, including the right to:

- Request restrictions on certain uses and disclosures. However, the facility is not obligated to agree to requested restrictions;
- Receive confidential communications or protected health information; ● Inspect and copy your protected health information with some limited exceptions; ● Amend your health information;
- Receive an accounting of disclosures of your health information;
- Obtain a copy of this notice.

The Facility's duties regarding the privacy of your health information:

Subject to limitations outlined by law, the Facility has certain duties related to your protected health information, including:

- The Facility is required by law to maintain the privacy of protected health information

and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

- The Facility is required to abide by the terms of the privacy notice that is currently in effect.
- The Facility reserves the right to change the privacy practices described in this notice and to make such changes effective for all protected health information. A Revised notice will be posted in our office and available upon request.

Concerns:

No individual will be retaliated against for filing a complaint.

Printed Name: ___________________________
Signature (Patient, Parent/Guardian, Representative): _______________________________
Relationship (if not client): ____________________ **Date**: ______________________________

Medical Information Release Form

Family and/or Friends

Name: ________________________ Date of Birth: _____/____/_____ EMR#:_____

[ ] I authorize the release of all information involving my care including the diagnosis, records; examination rendered to me and claims information.

[ ] I authorize the release of specific information involving my care. This is to include (please select below):

[ ] Visit Times/Dates
[ ] Lab Reports/Results
[ ] Visit Notes/Details
[ ] Other____

This information may be released to:

[ ] Spouse____

[ ] Child(ren)_______________________________________

[ ] Other____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed: ______________________________________ Date: ____/____/_____

Witness:______________________________________ Date: ___/____/_____

Acknowledgement of Mental Health, Alcohol and Drug Abuse Patient Records

The confidentiality of mental health, alcohol abuse and drug abuse shall be adhered to by the Facility. Patient records maintained by this program are protected by Federal laws and regulations. Generally, the program may not say to a person outside the program that a Patient attends the program, or disclose any information identifying a Patient as an alcohol abuser or drug abuser UNLESS:

1. The Patient consents in writing;
2. The disclosure is allowed by a court order, or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.

Violation of the Federal laws and regulations by a program is a crime. Suspected violations may be reported to the appropriate authorities in accordance with Federal regulations.

Federal laws and regulations do not protect any information about a crime committed by a Patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

I understand that my records are protected under Federal Confidentiality regulations (42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations) published August 10, 1987, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions.

Printed Name: ___________________________

Signature (Patient, Parent/Guardian, Representative): _______________________________

Relationship (if not client): ____________________ **Date**: ______________________________

OUT-OF-STATE OFFENDER CLIENT QUESTIONNAIRE

The following questions must be answered by all clients seeking admission to this program for any education or treatment; as required by Colorado law. Refusal to cooperate, or failure to provide complete or accurate information, including failure to sign a release of information to the referring criminal justice agency, will result in a denial to attend the treatment program and notification of authorities, in accord with the requirements in C.R.S. 17-27.1-101.

1) Are you required to report your treatment progress or completion to any Court, Department of Corrections, Parole, Probation, Adult Diversion Program, or the DMV? ____Yes____ No

2) Do you have any pending cases in another state? ____Yes ____No

If yes to 1 or 2, please answer the following questions:

3) What state are you completing treatment for?___________________

4) Who are you to report the treatment to? (Example: Court, Judge, Probation Parole, etc.)________________________________

5) Are you, or will you be under the supervision of a Probation or Parole Officer in Colorado? _____Yes _____No

6) For DUI Offenders only: Are you seeking education or treatment for the sole purpose of restoring you driving privileges as the result of an alcohol or drug related driving Offense in another state, but are not under court order to do so? ____Yes ____No

Your Name:_____________________________ Date of Birth:________________ Social Security Number:__________________ Place of Birth:________________________

Signature:______________________________ Today's Date:___________________ If you answered "Yes" to 1 or 2 above, please provide the following:

Name, address and phone number of your probation officer, parole officer, judge or diversion officer:
Name:____
Address:____
____
____
Phone:____

A copy of your probation, parole, court or diversion order, including treatment requirements must be included.

NOTICE OF PRIVACY PRACTICES & BILL OF RIGHTS ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

THE PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

The goal of Magnolia Medical is to provide all patients with high quality health care in a manner that clearly recognizes individuals' needs and rights. To accomplish this goal effectively, the patient and the health care provider must work together to develop and maintain optimum health. To promote this goal, the following rights and responsibilities have been identified:

AS A PATIENT, YOU HAVE THE RIGHT

1. To receive considerate care that is respectful of your personal beliefs, your cultural, and your spiritual values;
2. To have all things explained to you in terms that you can understand and to have any questions answered concerning your diagnosis, prognosis, and treatment;
3. To know what the diagnosis is; what your prognosis is; what treatment options are available to you; how risky the treatments are; and whether they will hurt, and for how long;
4. To have all the common side effects of a drug explained;
5. To know the contents of your medical records through interpretation by the provider; 6. To know who it is that is interviewing and examining you;
7. To have explained to you ways that you can prevent your medical problem from recurring;
8. To refuse to be examined or treated by a health practitioner and to be informed of the consequences of such a decision;
9. To be assured of the confidential treatment of disclosures in your record and to have the opportunity to approve or refuse the release of such information, except when the release of specific information is required by law or is necessary to safeguard you or the university community;
10. To be informed and asked whether you wish to participate in medical research that is being conducted at Health Services;
11. To participate in the consideration of ethical issues that arise in the provision of your care;
12. To receive care in a secure and private environment so that the treatment experience is positive and supportive;
13. To receive care in a timely and professional manner within available resources from a provider with whom you are comfortable;
14. To be heard when you have a concern regarding quality of care or patient safety with resolution by empowered staff or through submission of a formal Patient Care Survey or a more formal Incident Report to the Director;
15. To designate a Partner in Care (surrogate) decision-maker to participate with you and the provider in care decisions and delivery;
16. To have information provided regarding the health service fee, insurance requirements, cost of treatment, and payment options;
17. To have appropriate assessment and management of pain.

AS A PATIENT, YOU HAVE THE RESPONSIBILITY

1. To provide Health Services with information about past illnesses, hospitalizations, and medications;

2. To follow the plan of care or to express concern regarding your ability to comply;
3. To ask questions if you do not understand the directions or treatment being given to you by a provider;
4. To take responsibility for the outcome of your care if you have refused treatment;
5. To keep your appointment or to telephone Health Services, with reasonable notice, if you need to cancel;
6. To be respectful of others and others' property while in a Magnolia Medical facility;
7. To provide current and accurate insurance information to Magnolia Medical;
8. To be an active partner in arranging transition of care when no longer eligible for care. This includes arranging for recommended follow-up care and requesting copies of appropriate records be forwarded to a provider of your choice.

I have received, read and understand your Notice of Privacy Practices and Patient Rights containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change this Notice of Privacy Practices and Patient Rights from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices and Patient Rights..

I understand that I may request in writing that you restrict how my private information is used or Disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Printed Name: __________________________

Signature (Patient, Parent/Guardian, Representative): ______________________________ **Relationship (if not client)**: ___________________ **Date**: _____________________________