Magnolia Strong Group, Inc.

Patient Demographics

Name Status: S M D W		DOB	☐ M ☐ F
Street Address		SSN	
City		State	Zip
Driver's License No.	State	Home Phone	
Email Address		Cell Phone	
Primary Care Physician		PCP Phone	
Emergency Contact		Emergency Phone	
HOW WERE YOU REFERRED TO OUR OFFICE:			
EMPLOYER INFORMATION			
**Company		**Phone	
**Street Address		**Fax	
**City		**State	**Zip
HEALTH INSURANCE/WORK COMP/ATTORNEY INFORMATION			
Company		▶ **Date of Injury (if applicable)**	
Street Address		Claim/ID	Group
City	State / Zip	Phone	

****These sections need to be filled out if you have been involved in a work related injury**

▶ Please provide the date of injury if you were involved in an auto or work related injury

Health Insurance Portability and Accountability Act (HIPAA)

We at Magnolia Strong Group, Inc. understand that the medical information about you and your health is personal and we are committed to protect this information. Each day we create a record of the care and services you receive at our facility. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of the records of your care generated at our facility.

A HIPAA policy describes how health information about you may be used and disclosed and how you can get access to this information. State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a copy of our Privacy Notice.

A copy of our Privacy Notice will be provided to you upon request. By signing below you acknowledge you have either obtained a copy of our Privacy Notice, received satisfactory clarification of particular conditions, or choose to obtain a copy at a later date. You may request a copy of our Privacy Notice at any time by contacting our Privacy Office or Administrator at 817-921-3000.

BY SIGNING BELOW I ACKNOWLEDGE THAT THE INFORMATION PROVIDED ABOVE IS BOTH ACCURATE AND COMPLETE

_____ _____

Signature of Patient/Legal Guardian and Relationship to Patient *Date*

_____

Printed Name of Patient/Legal Guardian

1307 8th Avenue, Suite 201 * Fort Worth, Texas 76104
(817) 921-3000 Phone (817) 921-3001 Fax

Magnolia Strong Group, Inc.

Health History

Patient Name: **Date:**

MEDICAL HISTORY				
Abdominal Pain	Cancer/Tumors	Headache/Migraine	Parkinson's Disease	Suicide Attempt
Alcohol Use	Chest Pain	Herniated/Slipped Disc	Pinched Nerve	Thyroid Problems
AIDS/HIV	Constipation/Diarrhea	High Blood Pressure	Pneumonia	Tobacco Use
Allergies/Hay Fever	Cough	High Cholesterol	Prostate Problems	Tuberculosis
Anemia	Depression	Jaw Pain/Clicking	Psychiatric Care	Ulcers
Arthritis	Fibromyalgia	Kidney Disease	Seizure Disorder	Urinary Problems
Asthma	Fracture	Liver Disease	Shortness of Breath	Weight Gain/Loss
Bowel/Bladder Problems	Heart Disease	Osteoporosis	Skin Rash/Lesions	Other:
Bronchitis	Hepatitis	Pacemaker	Stroke	

Please list ALL Surgeries and Hospitalizations: _____

_____

Please list ALL Medications currently taking: _____

_____

List any medication Allergies and Sensitivities: _____

_____

Previous Injuries: Motor Vehicle Work Other: _____

Female Patient ONLY: Are you pregnant? Yes No Unsure Date of last menstrual period: _____

Job Description/Responsibilities					
Lifting 1-10 Pounds	Never	Occasionally	Frequently	Constantly	
Lifting 11-20 Pounds	Never	Occasionally	Frequently	Constantly	
Lifting 21-50 Pounds	Never	Occasionally	Frequently	Constantly	
Lifting >100 Pounds	Never	Occasionally	Frequently	Constantly	
Sitting	Never	Occasionally	Frequently	Constantly	
Standing	Never	Occasionally	Frequently	Constantly	
Kneeling/Squatting	Never	Occasionally	Frequently	Constantly	
Bending/Stooping	Never	Occasionally	Frequently	Constantly	
Pushing/Pulling	Never	Occasionally	Frequently	Constantly	
Twisting	Never	Occasionally	Frequently	Constantly	
Reaching	Never	Occasionally	Frequently	Constantly	

BY SIGNING BELOW I ACKNOWLEDGE THAT THE INFORMATION PROVIDED ABOVE IS BOTH ACCURATE AND COMPLETE

_____ _____

Signature of Patient/Legal Guardian and Relationship to Patient *Date*

_____

Printed Name of Patient/Legal Guardian

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Magnolia Strong Group, Inc.

CONSENT FOR TREATMENT

I, _____, hereby authorize, by my signature, **Magnolia Strong Group, Inc.,** and/or his licensed medical professionals such assistants, to evaluate and treat my condition; to render any and all medical care deemed necessary and any additional care and supplies that are recommended. I understand that the diagnosis or treatment of me by **Magnolia Strong Group, Inc.** and/or his employees may be conditioned upon my consent.

MEDICAL RECORD RELEASE: I consent to the use of disclosure of my protected health information by **Magnolia Strong Group, Inc.** for the purpose of diagnosis or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations by **Magnolia Strong Group, Inc.** My protected health information means health information, including demographic information collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected information relates to my past, resent or future physical, mental health condition, and identifies me, or there is a reasonable basis to believe the information may identify me.

THIRD PARTY LIABILITY: Magnolia Strong Group, Inc. does not believe that a liability case against a third party is reason to delay payment of services. I agree that payment for services rendered is not contingent upon any settlement judgment, or verdict of which they may eventually recover as a result of such liability cases. I agree to be ultimately responsible for payment in full for all services rendered in the event that a settlement is not reached or if my case is dropped by my attorney and I fail to contract with other legal counsel.

CIRCUMSTANTIAL RISK: I have been made aware of the possible benefits, effect and possible risk or complications associated with my care. I agree to accept the treatment prescribed to me and recognized that I am free to seek other opinions relating to my health.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Magnolia Strong Group, Inc.** has taken action in reliance to this consent.

By signing this authorization, I hereby consent to the programs develop by **Magnolia Strong Group, Inc.**

Patient Name (print): _____

Patient Signature: _____ Date: _____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____

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Magnolia Strong Group, Inc.

PARTIAL ASSIGNMENT OF THE CAUSES OF ACTION, ASSIGNMENT OF PROCEEDS CONTRACTUAL LIEN & AUTHORIZATION

Purpose. The purpose of this Assignment is to improve the ability of the Office to collect my Charges directly from various Payers. Accordingly, I agree to the following and direct all Payers as follows:

Definitions. In this Assignment, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to Magnolia Strong Group, Inc. "Payer" shall refer to, without limit, an insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds to me, either now or in the future, for any reason; "Proceeds" shall include, without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, and the proceeds relating to the following benefits, plans, or coverage: individual and group health benefits, Medicare, Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice, regardless of whether such Proceeds relate directly to my Charges or not; "Charges" shall include, without limit, the full fees for the Office's service (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, photocopies, depositions, and testimony), and Collection Costs incurred by the Office, interest and delinquency penalties to the extent permitted by law, and any other charges incurred by me at the Office; "Collection Costs" shall include, without limit, any pre and post judgment court costs, filing fees, service of process charges, attorney fees, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from my Payer.

Partial Assignment of the Causes of Action, Assignment of Proceeds, Contractual Lien. I hereby assign to the Office, in so far as permitted by law, but only to the extent of my Charges, all of my rights, and benefits relating to any Payer, including, without limit, my right to receive Proceeds from an Payer now or in the future, and any and all causes of action that I might have against any Payer now or in the future, the right to prosecute such causes of action either in my name or in the Office's name, and right to settle or otherwise resolve such causes of action as the Office sees fit. I further grant a contractual lien to the Office with respect to my Charges. I further intend for the Agreement to create a secured interest under the applicable Uniform Commercial Code and hereby direct the Office to file the form(s) normally filed with the secretary of state or other governmental agency in order to perfect such lien. Consistent with these provisions, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the extent of my Charges.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of any Proceeds received by the attorney is to pay my charges.

Other Disclosure Authorization. I hereby direct all Payers to release to the Office any pertinent information regarding any coverage I may have including, without limit, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize and direct the Office to release any information regarding my treatment or pertinent to my case(s), including, without limit, a copy of my Charges and a copy of this Assignment, to all Payers in order to facilitate collection of my Charges.

Miscellaneous Provisions. Except as provided in this paragraph, this Assignment shall not be modified or revoke without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment. I agree that each and every provisions of this Assignment is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Assignment be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment shall, nevertheless, remain in full force and effect. This Assignment shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action bases upon this Assignment, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens as such term is defined by law. I further waive any statute of limitations, which may apply in any action based upon this Assignment.

I have read, understood, and agree to the terms of this Assignment.

Patient Name (print): _____

Patient Signature: _____ Date: _____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____

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MAGNOLIA STRONG GROUP, INC.
DBA MAGNOLIA STRONG REHAB
1307 8TH AVENUE, SUITE 201
FORT WORTH, TEXAS 76104
(817) 921-3000 • FAX(81) 921-3001

Patient Name: _____

Date of Birth: _____ SSN: _____

Please allow _____ *(facility/hospital)* to release the following for all dates of services:

_____ X-ray Report _____ Medical Records _____ MRI Report

_____ CT Report _____ Operative Reports _____ Medication List

Please send to:

Magnolia Strong Group, Inc.
1307 8th Avenue, Suite 201
Fort Worth, Texas 76104
Phone (817) 921-3000
Fax (817) 921-3001
Email: info@magnoliastrong.com

_____ _____

Patient Signature *Date*