BAGWELL
MEDICAL CLINIC
Brian Bagwell, D.O.
4364 Highway 51 South
Senatobia, MS 38668-2534
BagwellMedicalClinic@comcast.net
Ph: (662) 560-5966
Fax: (662) 560-5969

Patient Information:

Last Name_____ First_____ MI_____ Date of Birth_____
Address_____City_____St_____Zip_____
Phone Home_____ Work_____Cell_____
Male___ Female____ Race _____Marital Status _____SSN _____
Email address_____Local Pharmacy_____ City_____
Mail Order Pharmacy _____
Do you have an Advanced Directives Plan / Living Will? Yes/No
Do you have a Medical/Legal Power of Attorney? Yes / No
Name_____Phone_____

Children only:

Mother's Name____ _____ Father's Name_____
Address _____ Address _____
City, St, Zip_____ City, St, Zip_____
Phone_____ Phone_____

Insurance:

Company_____ Policy/ ID#_____Group #_____
Member's Name_____ DOB_____SSN_____ Relationship_____

Employer_____ City_____ ST_____ Phone_____
Is this an accident? Yes____ No____ Work related? Yes ____ No____ Auto accident? Yes____ No____ Date of Injury_____

Notice of Financial Practices:

As part of an effort to provide the best possible medical care to you, we would like to explain our financial policies in advance.

- Your health insurance is a contract between you, your insurance company and, if applicable, your employer. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, coordination of benefits, or precertifications. Our professional services are rendered to you, not the insurance company, therefore payment for services is your responsibility. Not all services are covered benefits. Please understand that if your insurance does not pay for a particular service, you are responsible for payment in full. It is your responsibility to understand and know your insurance benefits and to inform our office of insurance benefit changes prior to the appointment. Co-pays and deductibles are due at time of service. If insurance is denied, you will be responsible for the total charges. We accept cash, checks, Visa, MasterCard, and Discover Card. All returned checks will be at $40.00 returned check fee.
- Any forms or letters requested (short-term disability, school, employment, etc) will be completed with a minimum charge of $25.00 each. We require 5-7 business days advanced notice to complete.
- There may be a charge of $25.00 for missed appointments without notice of cancellation since the booked appointment was kept open specifically for you. Walk-In are alwayss welcome,however, appointments are suggested as we take appointments first.
- Prescription refills- we generally do NOT phone in refills nor do we phone in new prescriptions without evaluation.
- Accounts that are past due may be turned over to a collection service. All fees incured as a result of past due account collections, including but not limited to court costs, will be your responsibility.

Privacy:

May we call you, a family member or significant other regarding scheduling, test results or other private issues?
Name _____Phone _____
Name _____ Phone _____
Name _____ Phone _____
May we leave a brief confidential message on voice mail or answering machine? Yes_____ No _____

EMERGENCY CONTACT: _____

I have read and understand the Health Information Notice, Financial Notice, and Privacy Notice. I hereby authorize payment directly to the business office of this clinic/provider for surgical &/or medical benefits for services provided. I understand that I am financially responsible for the charges not covered by insurance.

Patient Signature/Responsible Party_____

Relationship to Patient_____Date_____