MILLENNIUM
PHYSICIAN GROUP

PATIENT INFORMATION			
First Name:	Last Name:	Maiden Name:	Date of Birth: ☐ Male ☐ Female
Select One: ☐ Full Time Resident (Year Round) ☐ Winter Resident (Oct – Apr) ☐ Summer Resident (May – Sep)			
Street Address:			SS#:
City, State, Zip:			☐ Married ☐ Single ☐ Divorced ☐ Widowed
Home Phone	Cell Phone	Work Phone	Preferred Language:
Referring Physician:			Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino
☐ American Indian or Alaska Native _____			☐ Native Hawaiian or Other Pacific Islander _____
☐ Asian _____			☐ Other Race _____
☐ Black or African American _____			☐ White _____

EMERGENCY CONTACTS			
Name:	Relationship:	Phone:	Cell Phone:
Name:	Relationship:	Phone:	Cell Phone:
Name:	Relationship:	Phone:	Cell Phone:

GUARANTOR (if other than patient):		
Name:	Relationship:	
Street Address:	City, State, Zip:	
Home Phone:	Work Phone:	Cell Phone:

PRIMARY INSURANCE or MEDICARE	SECONDARY INSURANCE
☐ Same as Patient ☐ Same as Guarantor ☐ Other	☐ Same as Patient ☐ Same as Guarantor ☐ Other

PLEASE HAVE YOUR INSURANCE CARD(S) AVAILABLE TO BE PHOTOCOPIED FOR YOUR FILE!

To improve interactions and communications with our patients, we have implemented automated systems for phone messages and for email communications concerning appointment reminders, past due balance alerts, and disease management initiatives, etc. **May we place automated phone calls or email messages with you? ☐ Yes ☐ No If "Yes", please indicate preferences below:**

Health Notifications: order results posted on Patient Portal; reminder of orders overdue; disease management	**Appointment Reminders**	**Announcement:** appointment canceled, need to reschedule; missed appointment, need to reschedule	**Billing Information:** overdue balance
☐ Email ☐ Phone ☐ Text	☐ Email ☐ Phone ☐ Text	☐ Email ☐ Phone ☐ Text	☐ Email ☐ Phone ☐ Text

Email Address:	How did you hear about us? ☐ TV ☐ Radio ☐ Newspaper ☐ Friend ☐ Physician

ASSIGNMENT AND RELEASE:

- I hereby assign my insurance benefits to be paid directly to Millennium Physician Group.
- I agree to be solely responsible for all collection fees, attorney fees, and court costs necessary to collect payment on any portion of the delinquent balance, and, I hereby authorize MPG to conduct any and all financial investigative reports that they deem necessary to determine if service is to be provided and if any payment arrangements can be made.
- I understand that if I fail to cancel or reschedule an appointment, I may be charged a "No Show" fee.
- I authorize the physician to release any medical information required to process the claim.
- I authorize electronic communications from MPG for healthcare maintenance purposes (i e., emails, phone calls, and MPG-Communicator Portal messages).

Signature: _____ Date. _____

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Financial Policies and Information

PLEASE READ CAREFULLY

Our commitment is to provide the very best healthcare to you, our patient. Your clear understanding of- and agreement to- our financial policies concerning your medical care is fundamental to our professional relationship with you. Should you have additional questions about our fees and financial policies, or about your responsibilities relating to your insurance coverage, please contact the Practice Manager.

PROFESSIONAL FEES: Our prices are representative of the usual and customary charges for our area. Our fees reflect the Provider's time dedicated to your care. That time includes the review of any prior medical records, diagnostic testing, authorizations and other insurance requirements as well as the coordination of your care with other physicians involved in your health care planning.

INSURANCE PAYMENTS: We participate in assignment of payment with specific insurance plans in the State of Florida. Your insurance coverage is a contract between you and your insurance plan. It is your responsibility to verify and know your insurance benefit coverage including your out of pocket requirements. If your insurance plan is one with which we participate and if you have provided valid proof of insurance for that plan, we will submit your claim(s) as a courtesy to you, our patient.

PROOF OF INSURANCE: Before being seen by a Provider, you must complete the Patient Information Form, provide a driver's license or legal identification card; and, provide a current valid insurance card as proof of insurance. If the insurance information you provide is incorrect, you will be responsible for the balance of the claim.

PATIENT PAYMENTS/SELF-PAY BALANCES: Your co-payments and deductibles, services not covered by your insurance plan, and, self-pay balances are due at the time of your appointment. Your balances are due upon receipt of the Millennium Physician Group statement unless you have made other arrangements prior to the service being rendered. You may pay by cash, check or credit card. We accept Visa, MasterCard, Discover and American Express and encourage you to utilize the "Credit Card on File" program for easy and convenient balance resolution. After 90 days of non-payment, your account may be turned over to a collection agency.

APPOINTMENTS: Please understand that your appointment is time that has been reserved for your health care needs. If you are running late, please call us as soon as possible; if you need to cancel your office and/or procedure appointment, **please call us 24-hours in advance.** If you fail to show up for a scheduled office appointment, you may be assessed a $50 No Show fee that will be due on your next office visit.

NON-COVERED SERVICES: Some services you receive may be non-covered or may be considered not necessary by Medicare or other insurers You must pay for these services in full at the time of your visit.

MEDICARE BENEFICIARIES: Medicare will sometimes limit coverage of certain goods or services based on the diagnosis or the frequency in which they are performed. In the event that your provider identifies the potential for denial of your claim for either of these reasons, in accordance with Medicare requirements, you will be asked to complete an Advanced Beneficiary Notification Form (ABN) which will provide you the opportunity to be given the expected cost to you for the services – prior to services being rendered. You will be able to elect to receive the services and be responsible for the cost Medicare assigns, or, elect to decline the services.

COLLECTION AGENCIES: If it becomes necessary to place your account with a third party collection agency due to non-payment, you may be discharged from our Practice. Should this occur, we will treat you on an emergency basis only for the next 30 days while you find alternative medical care.

BOUNCED CHECKS: A $50 charge will be applied for each check returned by your bank. If you have had more than one bounced check, your Provider may elect to not accept future checks from you.

YOUR SIGNATURE ON THIS PAGE CONSTITUTES AN AGREEMENT TO THIS POLICY.

I have read and agree to the above Financial Policies and Information. I hereby assign all medical and/or surgical benefits to which I am entitled through my insurance - governmental or private – to Millennium Physician Group, LLC. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is considered as valid as the original.

Printed Name of Patient:______________________ Patient's D.O.B.: ______________

______________________ ______________________ ______________

Signature of Person Responsible for the Account Printed Name of Person Responsible for Account Date

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Patient Representative Authorization

Please write your NAME and DATE of BIRTH and THEN COMPLETE EITHER SECTION (1) or SECTION (2) of this form.

Patient Name: **Patient Date of Birth:**

(1.) I DO AUTHORIZE PATIENT REPRESENTATIVE(S) AS FOLLOWS:

I, _____, HEREBY AUTHORIZE MILLENNIUM PHYSICIAN GROUP PROVIDERS TO DISCUSS MY CARE/CONDITION WITH THE FOLLOWING PERSON(S):

Name: _____
Address: _____
City/State/Zip: _____
Relationship: _____
Phone #: _____

Name: _____
Address: _____
City/State/Zip: _____
Relationship: _____
Phone #: _____

Medical information that may be discussed/disclosed may include *(check all that apply):*

- ☐ Alcohol and/or Drug Abuse
- ☐ Mental Health
- ☐ Sexual Transmitted Disease (STD)
- ☐ Acquired Immunodeficiency Syndrome (AIDS)
- ☐ Human Immunodeficiency Virus (HIV) infection

This authorization to discuss/disclose my private health information to the designated person(s) named above ***shall expire*** *(please make a selection):*

- ☐ *12 months from the date of my signature below -- OR --*
- ☐ *When I revoke this authorization by sending written notification to MPG Provider.*

☐ *I understand that I have the right to inspect the medical records requested and that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by State or Federal Law.*

Print Name: _____ Signature: _____ DATE _____
Patient — Patient or parent/legal guardian signature if patient is minor

(2.) I DO NOT WANT TO AUTHORIZE PATIENT REPRESENTATIVE AT THIS TIME

☐ **I DO NOT WANT TO NAME A PATIENT REPRESENTATIVE AT THIS TIME.**

Print Name: _____ Signature: _____ DATE _____
Patient — (Patient or parent/legal guardian signature if patient is minor)

☐ **I would like to have copy of this authorization for my personal files.**

MILLENNIUM
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Patient Name: _____ **ID#** _____ **D.O.B.:** _____ **TODAY'S DATE:**

PATIENT'S CARE TEAM			
	Name/Specialty	**Address**	**Phone**
Primary Care Physician			
Specialists			

PHARMACY		
	Location/Address	Phone # (if known)
Preferred Pharmacy (local)		
Preferred Pharmacy (mail away		

MEDICATIONS: include herbal remedies, vitamins, frequent over-the-counter meds (aspirin, ibuprofen, Tylenol, Tums, etc.)		
Name	Dose-mg	Directions
1.		
2.		
3.		
4.		
5.		
6.		
7		
8.		
9.		
10.		

ALLERGIES	
Are you allergic to Contrast Dye?	☐ **YES** ☐ **NO**
Allergic to:	Reactions:
1.	
2.	
3.	
4.	
5.	
6.	

IMMUNIZATION					
Name:	Given:	Date:	Name:	Given:	Date:
Flu			Tetanus		
Pneumonia			Hepatitis		
Zostivax (shingles)			Other		

Patient Name: _____ **ID#**_____**D.O.B.:** _____**TODAY'S DATE:**

PAST MEDICAL HISTORY PLEASE CHECK ALL THAT APPLY	
☐ Alcohol Overuse	☐ Hepatitis
☐ Allergies (other than meds)	☐ High Blood Pressure
☐ Amputation (location)	☐ High Cholesterol
☐ Anemia	☐ HIV / AIDS
☐ Anxiety/Stress	☐ Hormone Replacement
☐ Arthritis	☐ Hospitalizations Other than operations
☐ Asthma	☐ Jaundice
☐ Back Pain	☐ Kidney Disease
☐ Barretts' Esophagus	☐ Kidney Stones
☐ Bleeding Disorder	☐ Measles / Mumps
☐ Blood Thinner Treatment	☐ Memory Loss/Alzheimer's
☐ Cancer (location)	☐ Nerve Damage/Neuropathy
☐ Cardiac Arrhythmias / Irregular Heart Rate	☐ Nervous Breakdown
☐ Cardiac Pacemaker / DeFib	☐ Osteopenia / Osteoporosis
☐ Chicken Pox	☐ Ostomies (location)
☐ Cirrhosis	☐ Other
☐ Colon Polyps	☐ Paralysis
☐ Colon Problems	☐ Parkinson's
☐ Congestive Heart Failure	☐ Prostate Problems
☐ Crohn's Disease	☐ Rash/Skin Condition
☐ Depression	☐ Rheumatic Fever
☐ Diabetes	☐ Seizures
☐ Emphysema / COPD	☐ Serious Injuries
☐ Erectile/Sexual Dysfunction	☐ Sexually Transmitted Dis.
☐ Falls	☐ Sleep Disorder / Insomnia
☐ Gallbladder Disease	☐ Stroke / TIA
☐ Gastritis	☐ Thyroid Disease
☐ GERD / Ulcer	☐ Urinary Problems
☐ Gout	☐ Vascular Disease
☐ Headaches / Migraines	☐ Vision Problems
☐ Heart Disease / Heart Attack	☐

SURGICAL HISTORY
PLEASE LIST ALL SURGERIES/PROCEDURES AND YEAR

	Surgery	Year
1.		
2		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
Do you have a Pace Maker? ☐ **YES** ☐ **NO**		

HEALTH MAINTENANCE PLEASE LIST DATE OF LAST EXAM	
	Year
Stress Test	
Echocardiogram	
EKG	
Chest X-Ray	
Mammogram	
Pap Smear	
PSA	
Bone Density	
Colonoscopy	

Patient Name: _____ **ID#**_____**D.O.B.:** _____**TODAY'S DATE:**

FAMILY HISTORY: **If a blood relative (parent, sibling, child) has any of the following, PLEASE CHECK AND INDICATE WHICH FAMILY MEMBER.**			
☐ Do not know Family History	☐ Mother is Living ☐ Mother is Deceased Age of Death: Cause of Death:		☐ Father is Living ☐ Father is Deceased Age of Death: Cause of Death:
☐ Alcoholism	☐ Diabetes	☐ Mental Illness	☐ Other
☐ Breast Cancer	☐ Heart Attack	☐ Osteoporosis	☐
☐ Colon/Rectal Cancer	☐ Heart Disease	☐ Skin Cancer	☐
☐ Colon Polyps	☐ High Blood Pressure	☐ Stroke	☐
☐ Depression	☐ High Cholesterol	☐ Suicide	☐

SOCIAL HISTORY:			
Occupation:		Retired: ☐ Yes ☐ No	
Marital Status: ☐ Married ☐ Widow/Widower ☐ Single ☐ Divorced		# of Children _____	# of Pregnancies ____
Alcohol: ☐ Yes ☐ No Type: _____ Frequency: Number of Drinks _____ ☐ day ☐ week ☐ month	Smoke: ☐ Yes ☐ No Frequency: # _____ Pack/Day Number of Years _____ Quit Date: _____	Exercise: ☐ Yes ☐ No Type: _____ Frequency: Number of Times _____ ☐ day ☐ week ☐ month	Illicit Drug Use ☐ Yes ☐ No ☐ Marijuana ☐ IV Drug Use

I hereby authorize Millennium Physician Group to obtain for my medical records any medication history that is automatically downloaded from the Pharmacy Benefits Manager through SureScripts.

Patient Signature:

I hereby authorize Millennium to disclose my medical records and health care information to other medical providers and facilities upon their request in connection with my medical care and treatment.

Patient Signature:

I hereby authorize Millennium to exchange my immunization history with the Florida Immunization Registry .

Patient Signature:

Section 381.026, Florida Statutes, addresses the Patient's Bill of Rights and
Florida law requires that your health care provider or health care facility recognize your rights
and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients.

A PATIENT HAS THE RIGHT TO:	A PATIENT IS RESPONSIBLE FOR:
Know what rules and regulations apply to his or her conduct. Be treated with courtesy and respect, with appreciation of his/her dignity, and, with protection of privacy. Receive a prompt and reasonable response to questions and requests.	Following health care facility conduct rules and regulations. Keeping appointments and, when unable to do so, notifying the health care provider or facility. 
Receive medical treatment or accommodations regardless of race, national origin, religion, handicap, or source of payment. Know who is providing the medical services, and, who is responsible for his/her care. Be given, by the health care provider, information such as diagnosis, planned course of treatment, alternatives, risks and prognosis. Know if medical treatment is for purposes of experimental research, and, to give his/her consent or refusal to participate in such research. Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.	Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications and any other information about his/her health. Reporting to the health care provider whether he/she understands a planned course of action and what is expected of him/her. Following the treatment plan recommended by the health care provider. Reporting unexpected changes in his/her condition to the health care provider. 
Refuse any treatment except as otherwise provided by law. Know what patient support services are available, including if an interpreter is available if the patient does not speak English.	His/her actions if treatment is refused or if the patient does not follow the health care provider's instructions. 
Receive, prior to treatment, a reasonable estimate of charges for medical care. Know whether the health care provider or facility accepts the Medicare assignment rate if the patient is covered by Medicare. Be given full information and necessary counseling on the availability of known financial resources for care. Receive a copy of an understandable itemized bill and, if requested, to have the charges explained. Express complaints regarding any violation of his/her rights.	Making sure financial responsibilities are carried out.