

Millennium Medical

Treating People, not Symptoms

5088 66th Street N.

St. Petersburg, FL 33709

Ph: 727-541-2675

Fax: 727-541-3956

www.millmd.com

WELCOME

Welcome to Millennium Medical, a place where we emphasize “patient care” rather than “symptom care” – offering a more effective way of achieving long-term wellness than the temporary damage control so common in today’s traditional medicine. Our goal is to provide excellent care where patient and doctor work together in a caring, nurturing and supportive environment.

Your first day in the office is a fact-finding mission. Consultation, examination, blood work and X-rays may be performed to help us thoroughly understand your complete medical picture. Only by understanding the origins of a medical issue can we take the first step towards achieving good health. Depending on your individual case, you may be referred to one of the many specialists here at Millennium Medical for additional testing and/or consultation.

Your next visit will more than likely consist of a report of findings, at which time a complete explanation of your condition will be given. You will have an opportunity to have your questions answered, our goals will be defined, and your treatment schedule will be discussed. We encourage and promote patient involvement, and we strive to give you a choice of treatment options, including traditional and alternative care.

In closing, we are excited to be involved in your healthcare. It’s time to rediscover what feeling your best feels like. It’s time to make **you** a priority. Please feel free to contact our patient services department if you need anything.

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ENROLLMENT FORM

Date: _____ Email Address: _____

Name: _____
First Middle Initial Last

Address: _____
Number & Street City State Zip

Birth Date: _____ Social Security #: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: _____ Relation: _____

Emergency Phone: _____ Spouse's Name: _____

Employer: _____ Work Phone: _____

Date of last doctor appt.: _____ Dr. Name: _____

Do you have a Living Will? _____ Yes _____ No

How were you referred to our office: _____

Have you been injured in an accident? Yes No When? _____

Work Related? Yes No or Auto related? Yes No

Primary Insurance Company: _____

Policy Holder: _____ Date of Birth: _____

Secondary Insurance Company: _____

Policy Holder: _____ Date of Birth: _____

ACCIDENT INFORMATION - Mark All That Apply

Print Name: _____ Date of Birth: _____

Signature: _____ Today's Date: _____

Date of Collision: _____ Time of Collision: _____ am / pm

Location of Collision: _____

Were you working at the time of collision?

YES

NO

Explain the accident in your own words:

Your vehicle make, model and year: _____

Other vehicle(s) make, model and year: _____

If not a vehicle, collision was with: _____

The road surface was:

Pavement

Gravel

Dirt

Other _____

The road conditions were:

Wet

Damp

Dry

Oily

Ice

Snow

Visibility at the time of accident was:

Sunny <input type="checkbox"/>	Cloudy <input type="checkbox"/>
Clear <input type="checkbox"/>	Raining <input type="checkbox"/>
Good <input type="checkbox"/>	Snowing <input type="checkbox"/>
Fair <input type="checkbox"/>	Fog <input type="checkbox"/>
Poor <input type="checkbox"/>	Other _____

Traffic conditions were:

Light

Moderate

Heavy

I was sitting in the:

Driver

Front Passenger

Front Middle

Left Rear

Middle Rear

Right Rear

I was a:

PEDESTRIAN

CYCLIST

STRUCK BY A VEHICLE

STRUCK A VEHICLE

ACCIDENT INFORMATION - Mark All That Apply

Were your hands on the steering wheel?

YES
NO

If YES, which hand(s)?

LEFT
RIGHT
BOTH

Was your foot on the brake?

YES
NO

Were you wearing glasses at the time of impact?

YES
NO

If YES, were they still in place after impact?

YES
NO

At the moment of impact, my vehicle was:

STOPPED
BRAKING
DECELERATING
ACCELERATING

At the moment of impact, the other vehicle was:

STOPPED
BRAKING
DECELERATING
ACCELERATING

What was the angle of impact?

FRONT
BACK
LEFT
RIGHT
OTHER _____

Was there more than one collision?

YES
NO

If YES, what was the angle of the second impact?

FRONT
BACK
LEFT
RIGHT
OTHER _____

What areas of your vehicle were damaged?

FRONT <input type="checkbox"/>	REAR <input type="checkbox"/>
RIGHT FRONT <input type="checkbox"/>	RIGHT REAR <input type="checkbox"/>
LEFT FRONT <input type="checkbox"/>	LEFT REAR <input type="checkbox"/>
RIGHT SIDE <input type="checkbox"/>	LEFT SIDE <input type="checkbox"/>
OTHER _____	

What areas of the other vehicle were damaged?

FRONT <input type="checkbox"/>	RIGHT REAR <input type="checkbox"/>
RIGHT FRONT <input type="checkbox"/>	LEFT REAR <input type="checkbox"/>
LEFT FRONT <input type="checkbox"/>	REAR <input type="checkbox"/>
RIGHT SIDE <input type="checkbox"/>	OTHER _____
LEFT SIDE <input type="checkbox"/>	

Patient's Initials:

ACCIDENT INFORMATION - Mark All That Apply

Where was the head rest in reference to your head?

LOW	<input type="checkbox"/>
MIDDLE	<input type="checkbox"/>
HIGH	<input type="checkbox"/>

Did your seat break or bend?

YES	<input type="checkbox"/>
NO	<input type="checkbox"/>

Where you surprised / startled by the impact?

YES	<input type="checkbox"/>
NO	<input type="checkbox"/>

If NO, how did you brace?

WITH HANDS	<input type="checkbox"/>
WITH FEET	<input type="checkbox"/>
OTHER	<input type="text"/>

Where was your head facing at the time of impact?

STRAIGHT AHEAD	<input type="checkbox"/>	BEHIND	<input type="checkbox"/>
LEFT	<input type="checkbox"/>	RIGHT	<input type="checkbox"/>
OTHER	<input type="text"/>		

Where was your body facing at the time of impact?

FORWARD	<input type="checkbox"/>	TURNED LEFT	<input type="checkbox"/>
LEANING LEFT	<input type="checkbox"/>	TURNED RIGHT	<input type="checkbox"/>
LEANING RIGHT	<input type="checkbox"/>	OTHER	<input type="text"/>

During the accident were you:

JOLTED	<input type="checkbox"/>	STUNNED	<input type="checkbox"/>
THROWN FORWARD	<input type="checkbox"/>	DAZED	<input type="checkbox"/>
THROWN BACKWARD	<input type="checkbox"/>	WHIPPED	<input type="checkbox"/>
THROWN LEFT	<input type="checkbox"/>	SLAMMED	<input type="checkbox"/>
THROWN RIGHT	<input type="checkbox"/>	OTHER	<input type="text"/>

What was the approximate speed of your vehicle when the accident occurred?

mph

What was the approximate speed of the other vehicle when the accident occurred?

mph

Did the accident push or move your vehicle?

YES	<input type="checkbox"/>
NO	<input type="checkbox"/>

If YES, how far? _____ feet. What direction? _____

Were you wearing a seat belt?

YES	<input type="checkbox"/>
NO	<input type="checkbox"/>

If YES, what type?

LAP BELT	<input type="checkbox"/>
SHOULDER BELT	<input type="checkbox"/>
BOTH	<input type="checkbox"/>

Patient's Initials:

ACCIDENT INFORMATION - Mark All That Apply

Did the airbags deploy?

YES
NO

If YES, were you struck by the air bag?

YES
NO

Did you sustain loss of consciousness at anytime as a result of the accident?

YES
NO

If YES, when? _____

For how long? _____

Do you have loss of memory of the accident?

YES
NO

Did you feel pain immediately after the accident?

YES
NO

Did you strike any body part in the vehicle at the time of impact?

YES
NO

If YES, what part of your body struck what:

	HEAD	CHEST	CHIN	SHOULDER R/L	ELBOW R/L	WRIST R/L	HAND R/L	KNEE R/L	FOOT R/L
STEERING WHEEL									
DASHBOARD									
WINDSHIELD									
LEFT SIDE DOOR									
RIGHT SIDE DOOR									
LEFT WINDOW									
RIGHT WINDOW									
ROOF									
OTHER									

Did you have any bleeding cuts / lacerations after impact?

YES
NO

If YES, describe: _____

Did you have any bruising after impact?

YES
NO

If YES, describe: _____

Patient's Initials:

POST ACCIDENT INFORMATION - Mark All That Apply

Immediately following the accident were you able to get out of the vehicle and walk?

YES	<input type="checkbox"/>
NO	<input type="checkbox"/>

Immediately following the accident how did you feel?

HEADACHE	<input type="checkbox"/>	WEAK	<input type="checkbox"/>
DIZZY	<input type="checkbox"/>	UPSET	<input type="checkbox"/>
DAZED	<input type="checkbox"/>	DISORIENTED	<input type="checkbox"/>
NAUSEOUS	<input type="checkbox"/>	NERVOUS	<input type="checkbox"/>
CONFUSED	<input type="checkbox"/>	OTHER	<input type="text"/>

Symptoms first appeared:

IMMEDIATELY	<input type="checkbox"/>
HOURS AFTER ACCIDENT	<input type="checkbox"/>
NEXT DAY	<input type="checkbox"/>
DAYS AFTER ACCIDENT	<input type="checkbox"/>

Directly following the accident, I went:

HOME	<input type="checkbox"/>
WORK	<input type="checkbox"/>
HOSPITAL	<input type="checkbox"/>
PHYSICIAN	<input type="checkbox"/>
OTHER	<input type="text"/>

Were you able to drive away from the accident?

YES	<input type="checkbox"/>
NO	<input type="checkbox"/>

Since the accident I currently have or have had the following NEW symptoms:

JAW PROBLEMS	<input type="checkbox"/>	LEG PAIN L / R	<input type="checkbox"/>	FORGETFUL / FOGGY	<input type="checkbox"/>	NAUSEA	<input type="checkbox"/>
NECK PAIN	<input type="checkbox"/>	FOOT PAIN L / R	<input type="checkbox"/>	LIGHT-HEADEDNESS	<input type="checkbox"/>	VOMITING	<input type="checkbox"/>
UPPER BACK PAIN	<input type="checkbox"/>	CHEST PAIN	<input type="checkbox"/>	DIZZINESS	<input type="checkbox"/>	UPSET STOMACH	<input type="checkbox"/>
MID BACK PAIN	<input type="checkbox"/>	HEADACHES	<input type="checkbox"/>	TENSION	<input type="checkbox"/>	RINGING IN EAR	<input type="checkbox"/>
LOWER BACK PAIN	<input type="checkbox"/>	HEAD PRESSURE	<input type="checkbox"/>	DIS-ORIENTATION	<input type="checkbox"/>	BLURRED VISION	<input type="checkbox"/>
SHOULDER PAIN L / R	<input type="checkbox"/>	STIFFNESS	<input type="checkbox"/>	RESTLESSNES S	<input type="checkbox"/>	INABILITY TO FOCUS EYES	<input type="checkbox"/>
ARM PAIN L / R	<input type="checkbox"/>	DIFFICULTY SLEEPING	<input type="checkbox"/>	PARALYSIS	<input type="checkbox"/>	SHORTNESS OF BREATH	<input type="checkbox"/>
HIP PAIN L / R	<input type="checkbox"/>	IRRITABILITY	<input type="checkbox"/>	CONSTIPATION	<input type="checkbox"/>	NUMBNESS	<input type="checkbox"/>
THIGH PAIN	<input type="checkbox"/>	INABILITY TO FOCUS MIND	<input type="checkbox"/>	DIARRHEA	<input type="checkbox"/>	TINGLING	<input type="checkbox"/>
KNEE PAIN L / R	<input type="checkbox"/>	MEMORY LOSS	<input type="checkbox"/>	URINARY PROBLEMS	<input type="checkbox"/>	BLEEDING	<input type="checkbox"/>

Patient's Initials:

POST ACCIDENT INFORMATION - Mark All That Apply

List below the 3 symptoms that are of your most concern.

Mark the CURRENT pain level you are having and mark on the diagram the exact location of the pain.

Mark the diagram: **A** = ACHING **N** = NUMBNESS **T** = TINGLING **D** = DULL
SH = SHARP **B** = BURNING **S** = STIFFNES **TH** = THROBBING

If the pain travels from one location to another, draw a line from beginning to end and.

Symptom you are most concerned about:

0 1 2 3 4 5 6 7 8 9 10
 NONE | LITTLE | MORE | AWFUL | WORST

Pain Level: _____

Mark Area:

Second symptom you are most concerned about:

0 1 2 3 4 5 6 7 8 9 10
 NONE | LITTLE | MORE | AWFUL | WORST

Pain Level: _____

Mark Area:

Third symptom you are most concerned about:

0 1 2 3 4 5 6 7 8 9 10
 NONE | LITTLE | MORE | AWFUL | WORST

Pain Level: _____

Mark Area:

Patient's Initials:

POST ACCIDENT INFORMATION - Mark All That Apply

Since the accident my symptoms overall have:

IMPROVED	<input type="checkbox"/>
WORSENERD	<input type="checkbox"/>
STAYED THE SAME	<input type="checkbox"/>

Describe in your own words how you felt after the accident and the changes in these symptoms, make sure to use any symptoms listed above as well as any additional symptoms not listed:

Immediately after accident:

Two to three hours after accident:

That night:

Next day:

Two to Five Days Later:

Other:

Since the accident my symptoms are effecting my:

WORK	<input type="checkbox"/>
SLEEP	<input type="checkbox"/>
HOUSEHOLD DUTIES	<input type="checkbox"/>
HOBBIES / RECREATION	<input type="checkbox"/>

Since the accident I have trouble with:

LAYING ON BACK	<input type="checkbox"/>	SEXUAL ACTIVITIES	<input type="checkbox"/>
LAYING ON LEFT SIDE	<input type="checkbox"/>	WALKING	<input type="checkbox"/>
LAYING ON RIGHT SIDE	<input type="checkbox"/>	RUNNING	<input type="checkbox"/>
SITTING	<input type="checkbox"/>	SPORTS	<input type="checkbox"/>
STANDING	<input type="checkbox"/>	WORKING	<input type="checkbox"/>
STRETCHING	<input type="checkbox"/>	LIFTING	<input type="checkbox"/>

OTHER _____

BENDING	<input type="checkbox"/>
KNEELING	<input type="checkbox"/>
PULLING	<input type="checkbox"/>
REACHING	<input type="checkbox"/>
EXERCISE	<input type="checkbox"/>

Patient's Initials:

WORK - Mark All That Apply

Are the symptoms from the accident affecting your ability to work?

YES	<input type="checkbox"/>
NO	<input type="checkbox"/>

What is your profession:

How many hours a day do you work?

How many days a week do you work?

Which job duties are most affected by your symptoms:

STANDING	<input type="checkbox"/>	CRAWLING	<input type="checkbox"/>
TWISTING	<input type="checkbox"/>	STOOPING	<input type="checkbox"/>
BENDING	<input type="checkbox"/>	TYPING	<input type="checkbox"/>
LIFTING	<input type="checkbox"/>	DRIVE	<input type="checkbox"/>
SITTING	<input type="checkbox"/>	OPERATING EQUIPMENT	<input type="checkbox"/>
WALKING	<input type="checkbox"/>	ARMS ABOVE HEAD	<input type="checkbox"/>

Do you have an option of light duty work?

YES	<input type="checkbox"/>
NO	<input type="checkbox"/>

POLICE - Mark All That Apply

Was the accident reported to the police?

YES	<input type="checkbox"/>
NO	<input type="checkbox"/>

Were citations issued?

YES	<input type="checkbox"/>
NO	<input type="checkbox"/>

If YES, to whom?

Was a police report filed?

YES	<input type="checkbox"/>
NO	<input type="checkbox"/>

Do you have a copy of the report?

YES	<input type="checkbox"/>
NO	<input type="checkbox"/>

Patient's Initials:

HOSPITAL - Mark All That Apply

Did you go to the hospital?

YES	<input type="checkbox"/>
NO	<input type="checkbox"/>

If YES, how did you get there?

AMBULANCE	<input type="checkbox"/>
POLICE CAR	<input type="checkbox"/>
PRIVATE TRANSPORTATION	<input type="checkbox"/>

Were you admitted?

YES	<input type="checkbox"/>
NO	<input type="checkbox"/>

If YES:

How long?

What hospital?

What doctor?

What diagnostic procedures?

NONE	<input type="checkbox"/>
X-Rays	<input type="checkbox"/>
MRI	<input type="checkbox"/>
EXAM	<input type="checkbox"/>
OTHER	<input type="checkbox"/>

What treatment was provided?

PAIN MEDICATION	<input type="checkbox"/>
MUSCLE RELAXANTS	<input type="checkbox"/>
CERVICAL COLLAR	<input type="checkbox"/>
PHYSICAL THERAPY	<input type="checkbox"/>
STITCHES	<input type="checkbox"/>

CAST	<input type="checkbox"/>
REFERRAL	<input type="checkbox"/>
OTHER	<input type="checkbox"/>

Have you sought care with any other physician in regards to this injury?

YES	<input type="checkbox"/>
NO	<input type="checkbox"/>

If YES, with whom?

What diagnosis and therapy were provided?

Was anyone, other than you, required to be taken directly to the hospital?

YES	<input type="checkbox"/>
NO	<input type="checkbox"/>

If YES, who?

Patient's Initials:

MEDICAL - Mark All That Apply

If you are currently taking any medications or supplements, please list them here:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If you have any known allergies, please list them here:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If you have any major medical problems, please list them here (i.e. heart condition, kidney failure):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If you are under the care of any other health care providers, please list their names and specialties here:

<u>Provider's Name</u>	<u>Provider's Specialty:</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient's Initials:

Millennium Medical

Controlled Substances Agreement

Patient Name: _____ Date of Birth: _____

This agreement is to inform you about the controlled substances policies of the Medical Department of Millennium Medical. Pain control is a partnership effort between you and your doctor. This agreement is adapted from guidelines set forth by the Florida Board of Osteopathic Medicine on a review of Rule 64B15-14.005 of the State of Florida. Millennium Medical's controlled substances policy must be agreed to by you, the patient, in its entirety. The policy is as follows:

1. Controlled substances are to be prescribed by only one doctor and filled at only one pharmacy. If you receive a controlled substance from another physician, you must report it to our office within one (1) business day.
2. Prescriptions are only available at regularly scheduled office appointments. These medications will not be called into the pharmacy and prescriptions will not be written without an appointment.
3. Any lost, stolen or otherwise missing prescriptions will not be replaced – no matter what the circumstances. There are no early refills and no exceptions.
4. The patient agrees to urine and/or serum drug lab testing as requested by the doctor without advanced notice (the cost of which becomes the patient's responsibility). Furthermore, the patient agrees to abstain from any recreational or illegal drugs and alcohol while under treatment.
5. We generally **DO NOT** write prescriptions for the following medications or compounds containing them: **Morphine, Oxycodone, Percodan, Percoset, Fentanyl, Demerol and Dilaudid.**
6. You are entitled to know about your medicine including risks, benefits, side effects, and other pertinent information. Your doctor will be glad to discuss these with you. Please relay any concerns or questions to your doctor so that your comfort and safety are ensured.
7. We generally **DO NOT** write prescriptions for narcotics for chronic pain on your initial visit to Millennium Medical. If, after discussion with you, we agree that part of your care plan includes the need for narcotic pain medication, we will limit your initial prescription to one week's worth of medication. We also reserve the right to call your pharmacy or other healthcare facilities to confirm compliance with our policy
8. If your care plan includes other therapies, such as massage, chiropractic, physical therapy or acupuncture, we will expect you to comply with that plan.
9. We will be glad to refer you to a pain management specialist if these policies do not meet your pain management needs.

On a scale from 1 to 10, please rate your pain when it's at its worst (0 = no pain, 10 = worst pain): _____

What are your goals in regards to your pain treatment? (Check all that apply)

Pain relief Increased activity Ability to work Ability to sleep Other: _____

Do you now, or have you ever used/abused any drugs? Please list them and dates used.

Do you now, or have you ever used/abused alcohol? Please list what kind, how much, and when.

By signing here, I agree to the controlled substance policy of the Medical Department of Millennium Medical. I understand that any violations of this policy, including refusal to submit to requested testing, failure to keep appointments, or other violations, will result in immediate cancellation of all controlled substance prescriptions, and possible dismissal from the practice. This cancellation will remain in effect until these violations have been remedied to the satisfaction of the attending physician.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Millennium Medical

Laboratory and Prescription Information

Patient Name: _____ Date of Birth: _____

Laboratory Policy

If you are required by your insurance company to use a specific laboratory, please list the name of the laboratory as you will be responsible to know this information:

If no laboratory is indicated, we will use Clinical Pathology Laboratory.

The laboratory used will bill you separately for services rendered. If you have any questions regarding these bills you may contact the laboratory directly or contact our medical department at 727-541-2675.

Prescription Policy

We refill prescriptions only during office hours. It may take up to **72 hours** for these requests to be completed. It is our office policy that on-call doctors will NOT be paged for refills. In order to obtain your refill in the timeliest manner please call your pharmacy and have them fax over your refill request.

Controlled substances will be filled **only via regularly scheduled appointments with the medical doctors**, no matter what the circumstances. **Any** lost, stolen, or otherwise missing controlled substance prescriptions will **not** be refilled.

If you have any questions regarding prescriptions services, please contact our medical department at 727-541-2675.

My signature below is an agreement that I have read and understand the above information.

Patient Name: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Millennium Medical

Missed Appointment Policy

Patient Name: _____ Date of Birth: _____

We are glad you have chosen us to provide your care, but if you miss appointments, you compromise that care. We want to remind you of our office policies regarding missed appointments. A missed appointment is when you fail to show up for an appointment without a phone call, or cancel without at least 24 hours notice.

We feel the doctor/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your scheduled appointments, and ask that you give us the same courtesy of a call when you are unable to keep your appointment.

Our office follows the process below if you miss your appointment.

1. 1st missed appointment: we will call and offer to reschedule the appointment. You *may* be charged a missed appointment fee of \$25.
2. 2nd missed appointment: we will call and offer to reschedule the appointment. You *will* be charged a missed appointment fee of \$25.
3. Consecutive missed appointments: you *will* be charged a missed appointment fee of \$25 and this *may* result in discharge from the practice.

For Functional Medicine, with Dr. Bangtson, our office follows the process below if you miss your appointment.

1. 1st missed appointment: we will call and offer to reschedule the appointment. You *may* be charged a missed appointment fee of \$50.
2. 2nd missed appointment: we will call and offer to reschedule the appointment. You *will* be charged a missed appointment fee of \$50.
3. Consecutive missed appointments: you *will* be charged a missed appointment fee of \$50 and this *may* result in discharge from the practice.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Millennium Medical

Patient Consent for Use and Disclosure of Protected Health Information

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

I hereby give my consent for Millennium Medical to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Millennium Medical describes such uses and disclosures more completely).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Millennium Medical reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to, the Office Manager at Millennium Medical located at 5088 66th St. North, St. Petersburg, FL 33709.

With this consent, Millennium Medical may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Millennium Medical may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

Millennium Medical has my permission to discuss / disclose my PHI to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

By signing this form, I am consenting to allow Millennium Medical to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Millennium Medical may decline to provide treatment to me.

MILLENNIUM MEDICAL NOTICE OF PRIVACY/PATIENT RIGHTS AND RESPONSIBILITIES

I, the Patient or his/her legal guardian, understand that by signing this agreement I voluntarily authorize provision of products and services to Patient by the provider named above. I have received written and /or oral information about the prescribed treatment and I understand the risks involved. I understand that products and services are prescribed by the Patient's physician, and it is necessary the Patient remain in the care of his/her physician throughout the course of treatment. I have reviewed information about Patients right/Responsibilities, Privacy Notice and Advance Beneficiary notice and had the Patients Right/Responsibilities explained to me.

Your health information is contained in a medical record that is the physical property of Millennium Medical. Millennium Medical uses health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. Under the federal HIPAA regulations, you and Millennium Medical have certain rights and restrictions relating to the uses and disclosures of your information. Among its obligations, Millennium Medical is required to maintain the privacy of protected health information; provide you notice of its legal duties and privacy practices; notify you if we are unable to agree to a requested restriction on how your information is used or disclosed; accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations; and obtain your written authorization to use or disclose your health information for certain defined reasons. **THE FULL TEXT OF MILLENNIUM MEDICAL'S PRIVACY NOTICE IS ON DISPLAY IN THE MAIN WAITING AREA. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Patient Signature: _____ **Date:** _____

Parent or Guardian Signature: _____ **Date:** _____

Millennium Medical

PIP Assignment of Benefits and Authorization of Services and Payment

Patient Name: _____ Date of Birth: _____

For good and valuable consideration, including the agreement of Millennium Medical, Inc., to accept this assignment in lieu of demanding full payment for services from the undersigned on the date each service is rendered, the undersigned patient executes this document hereby assigning to Millennium Medical, Inc. the right to receive insurance benefits and/or any information pertinent to my case directly from any insurance company, adjuster, or attorney that may be obligated to provide insurance benefits, for services rendered by Millennium Medical, Inc. for a motor vehicle accident that occurred on or about _____.

Any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, for the aforesaid accident for services provided by Millennium Medical, Inc., is hereby directed to issue payment for those benefits directly to and payable to: Millennium Medical, Inc.
5088 66th Street N
St. Petersburg, FL 33709

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment, including but not limited to deductibles, co-payments, co-insurance, products and services not covered by my insurance company or third party payor unless such liability is expressly waived by state or federal law. I agree to pay reasonable attorneys' fees and costs of collection of any past due patient balances if this account is referred to an attorney or agency for collection. I understand that it is difficult to predict the dollar amount I will be responsible for and Millennium Medical, Inc. reserves the right to revise any estimates based upon changes in physician order and/or change in payor coverage eligibility.

I also authorize and assign to Millennium Medical, Inc. the right to appeal, file suit and pursue all legal remedies to obtain payment for services provided to me by Millennium Medical, Inc. This authorization to file suit is an assignment of my cause of action to obtain payment for services provided to me by Millennium Medical, Inc. and includes the assignment to pursue declaratory relief or any other legal remedies. Millennium Medical, Inc. accepts the aforesaid assignment and hereby notifies any insurer issuing payment that Millennium Medical, Inc. objects to any "repricing" or reduction of billed amounts unilaterally made by an insurer. Any such reduced payments issued by any insurer are accepted under protest and without waiving any right of the provider to pursue all legal remedies against the insurer.

I authorize the release of medical information necessary to pay the claim. I authorize any holder of my medical information to release to Millennium Medical, Inc. and its agents any information needed to determine benefits payable for products and services. Millennium Medical, Inc. has advised me that I may request an itemized statement from Millennium Medical, Inc.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize Millennium Medical to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Payment for co-pays and deductibles is required at the time of service. Payment for supports (braces, cervical pillows, etc.) and supplements (vitamins and/or herbs) is expected at time of receipt. All sales are final. Our office accepts Visa/MasterCard, American Express, Discover, Debit cards, cash, or checks for services and products. **Please contact the office if you are confused about any aspect of your treatment or bill.** We are here to help you, but you need to inform us about any problem or confusion you may have.

I have read this document completely before signing. I completely understand this document or have had any questions about this document fully explained to me. My signature below is my agreement that I fully understand this document and fully agree to the terms of this document.

Patient's Signature: _____ Date: _____

Parent or Guardian if Applicable: _____ Date: _____

Authorized signatory for medical provider _____ Date _____



OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered**. This means that those services have **already been provided**.

- 2. I have the right and the **duty to confirm** that the services have already been provided.
- 3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
- 4. The medical provider has **explained** the services to me for which payment is being claimed.
- 5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to \$500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name (<i>PRINT or TYPE</i>)	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

- A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.
- B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.
- C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.
- D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable (*Signature by his/ her own hand*):

Name (<i>PRINT or TYPE</i>)	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.