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

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		
Home Phone	Cell Phone		Work 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!

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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GENERAL CONSENT FOR EVALUATION AND TREATMENT OF PATIENTS

I voluntarily consent to the performance of reasonable and necessary medical examinations, testing, and treatment provided by Millennium Physician Group (MPG) and its associated healthcare providers (physicians, nurse practitioner, and physician assistant), clinicians, and other staff. You have the right to discuss the treatment plan with your healthcare provider about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your healthcare provider, we encourage you to ask questions. I voluntarily request a MPG healthcare provider (or their designees as deemed necessary), clinician, or other staff to perform reasonable and necessary a medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and fully and voluntarily consent to its contents.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient

AGREEMENT FOR SERVICES

I hereby assign insurance benefits otherwise payable to me to be paid directly to Millennium Physician Group (MPG). I understand that I am responsible for charges not covered by my policy. 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 they deem necessary to determine if service is to be provided and if any payment arrangements can be made.

I further authorize MPG 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.

MILLENNIUM HEALTHCARE	FINANCIAL POLICY		Medical Record #:
Patient Name:	**Date:**	**DOB:**	□ **Male** □ **Female**

PLEASE READ CAREFULLY

Our commitment is to provide the very best healthcare for you, our patient. Your clear understanding of- and agreement with- our financial policy concerning your medical care is fundamental to our professional relationship with you. Should you have additional questions about our fees and financial policies please contact our Central Billing Office at 877-856-3774. If you have a question concerning your individual benefits including your out-of-pocket responsibilities outlined in your plan, please contact your carrier directly.

PROFESSIONAL FEES: Our prices are representative of the usual and customary charges for our area. Our fees reflect the Provider's time dedicated and complexity 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, outstanding balances, services not covered by your insurance plan, and self-pay services 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 encourage you to use our secure Credit Card on File program for easy and convenient resolution of your balance. We accept Visa, MasterCard, Discover and American Express. After 90 days of non-payment, your account may be turned over to a collection agency.

APPOINTMENTS: Please understand that your appointment time 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**.

SPLIT VISIT CARE: Some insurance plans allow for Preventative Care services (i.e., Annual Wellness Visit or Physical) to be performed by the provider on the same day as a problem focused visit, while others require the services be performed on separate days. When Preventative Services are combined with a problem-focused visit, any applicable co-pays, co-insurance or deductibles may still apply as they relate to your problem-focused care. It is your responsibility to know your specific coverage requirements and any limitations that may apply.

Effective Date: 20240101
Reviewed/Revised Dates: 20181212, 20220412

MILLENNIUM HEALTHCARE	FINANCIAL POLICY		Medical Record #:
Patient Name:	**Date:**	**DOB:**	□ **Male** □ **Female**

NON-COVERED SERVICES: Some services you receive may be non-covered under your policy or may be considered not necessary by Medicare or other insurers. If your carrier determines this to be your responsibility you will be required to pay these charges.

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 considered for discharge from our Practice. In the event you are discharged from our practice, we will treat you on an emergency basis only for the next 30 days while you find alternative medical care. Millennium reserves the right to request an active credit card to be placed on file for future services to be rendered and prompt resolution of future balances.

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 THE FINANCIAL POLICY

I have read and agree with the above Financial Policy 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.

Print Patient Name: _____ Patient's D.O.B.: _____

Signature of Person Responsible for the Account: _____

Printed Name of Person Responsible for Account: _____

Date: _____

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PHYSICIAN GROUP

PATIENT INFORMATION			
First Name:	Last Name:	Maiden Name:	Date of Birth: □ Male □ Female

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. ***Please indicate your preferences below.***

Appointment Reminders • Emailed 4 days prior • Called/Texted 1-2 days prior No messages left on weekends	□ Yes, please send via email to: _____ □ Yes, please send via phone to: _____ □ Yes, please send via text to: _____ *Patient Signature:*	□ No thank you. *Patient Signature:*
Billing Information • Automated reminder of your past due balance	□ Yes, please send via email to: _____ □ Yes, please send via phone to: _____ □ Yes, please send via text to: _____ *Patient Signature*:	□ No thank you. *Patient Signature:*
Health Notifications • Order results posted on your patient portal • Reminder of your overdue orders • Disease management initiatives	□ Yes, please send via email to: _____ □ Yes, please send via phone to: _____ □ Yes, please send via text to: _____ *Patient Signature:*	□ No thank you. *Patient Signature:*

Company Announcements • Appointment cancelled due to schedule conflict • Reminder to schedule follow up appointment • Reminder to call office to reschedule when you've missed an appointment	□ Yes, please send via email to: _____ □ Yes, please send via phone to: _____ □ Yes, please send via text to: _____ *Patient Signature:*	□ No thank you. *Patient Signature:*

To maximize the continuity of care and safety of our patients, we have implemented automated systems of communication with Pharmacy Benefits Manager, with other medical providers and facilities (upon request), and, with the Florida Immunization Registry. ***Please indicate your preferences below.***

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:*	□ No thank you. Signature:
I hereby authorize Millennium to disclose my medical records and health care information to O**ther Medical Providers and Facilities** upon their request in connection with my medical care and treatment. *Patient Signature:*	□ No thank you. Signature:
I hereby authorize Millennium to exchange my immunization history with the **Florida Immunization Registry**. *Patient Signature:*	□ No thank you. Signature:

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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.**

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Section 381.026, Florida Statutes

Florida law requires that your health care provider and/or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of its patients.

A PATIENT HAS THE RIGHT TO:

- Know what rules and regulations apply to his or her conduct.
- Be treated with courtesy and respect, with appreciation of his or her individual dignity, and, with protection of his or her need for privacy.
- Receive a prompt and reasonable response to questions and requests.
- Impartial medical treatment or accommodations regardless of race, national origin, religion, handicap, sexual orientation, or source of payment.
- Know who is providing the medical services, and who is responsible for his or 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 or her consent or refusal to participate in such research.
- Bring any person of his or her choosing to the patient-accessible areas of the health care facility to accompany the patient while patient is receiving treatment or is consulting with his or her health care provider unless doing so would risk the safety or health of the patient, other patients, staff of the facility, or cannot be reasonably accommodated.
- Refuse any treatment except as otherwise provided by law.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Receive, upon request and prior to treatment, a reasonable estimate of charges for medical care.
- Know, upon request and in advance of treatment whether the health care provider or health care facility accepts the Medicare assignment rate if he or she is eligible for Medicare.
- Receive, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- Know what patient support services are available, including if an interpreter is available if the patient has hearing or vision loss, or does not speak English.
- Receive a copy of a reasonably clear, understandable itemized bill and, upon request, to have the charges explained.
- Express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate licensing agency.

A PATIENT IS RESPONSIBLE FOR:

- Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications and any other matter relating to his or her health.
- Reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or her.
- Following the treatment plan recommended by the health care provider.
- Reporting unexpected changes in his or her condition to the health care provider.
- His or her actions if treatment is refused or if he or she does not follow the health care provider's instructions.
- Following health care provider's or health care facility's conduct rules and regulations.
- Keeping appointments and, when unable to do so, notifying the health care provider or facility.
- Assuring that financial obligations of his or her health care are fulfilled as promptly as possible.