Patient Information

Name: _____

Address: _____

City:_____ State: _____ Zip:_____

Date of Birth: _____ Home Phone:_____ Cell: _____

Sex: *Male /* *Female* E-mail: _____

Social Security Number: _____

********The subscriber's social and/or date of birth are imperative to filing your claims with your insurance. If we do not have this information when it comes time to file your claims, financial responsibility will be transferred to you.********

Emergency Contact

Name	Relationship	Phone Number	Alternate Number

Keep in mind if you do not list anybody on the bottom we will not be able to release any information…

I authorize Millennium Family Practice to disclose my protected health information to:

Name	Phone number	Relationship	Leave Messages Yes or No?
Name	Phone number	Relationship	Leave Messages Yes or No?
Name	Phone number	Relationship	Leave Messages Yes or No?

Feel free to fax this packet back to (281) 359-2421

Patient Responsibility for Controlled Substance Prescriptions

Controlled substance medications (i.e. narcotics, tranquilizers and barbiturates) are very useful but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. Because my physician is prescribing controlled substance medications to help manage my symptoms, I agree to the following conditions:

1. I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, misplaced, or stolen or if I "run out early," I understand that it will not be replaced.

2. Refills of controlled substance medications:

   a. Will be made only during regular office hours Monday through Friday, in person, every 6 months, during a scheduled office visit. Refills will not be made at night, on weekends, or during holidays. No refills by phone.

   b. Will not be made if I "run out early," or "lose a prescription," or "spill or misplace my medication." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.

   c. Will not be made as an "emergency," such as on Friday afternoon because I suddenly realize I will "run out tomorrow." I will call at least 7 days in advance if I need assistance with a refill. My prescription must be refilled in person in the office.

3. It may be deemed necessary by my doctor, that I see a medication-use specialist at any time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medication may be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction), my medications will no longer be refilled.

4. I agree to comply with random urine, blood, or breath testing, documenting the proper use of my medications as well as confirming compliance. I understand that it is my responsibility to comply with the laws of the state while taking the prescribed medications.

5. I understand that if I violate any of the above conditions, my prescription for controlled substance medications may be terminated immediately. If the violation involves obtaining controlled substance medications from another individual, or the concomitant use of non prescribed illicit (illegal) drugs, I may also be reported to all my physicians, medical facilities, and appropriate authorities.

7. I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances.

8. I agree to have all prescriptions for controlled substances filled at the same pharmacy. Should the need arise to change pharmacies, the practice will be notified. The pharmacy I have selected is:

Name:_____ Phone: _____

I understand the possibility of psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to the medication, necessitating a dose increase to achieve the desired effect, and there is a risk of becoming physically dependent on the medication.

In addition, I fully understand the consequences of violating this agreement.

Patient Signature: _____ Date: _____

Printed Name: _____

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

All co-pays and account payments are due at the time services are rendered. If any payment arrangements need to be made, please speak with the office manager prior to your appointment date.

Please understand that there is a fee of $25.00 for any appointments not cancelled 24 hours in advance. Leaving a message with the answering service is not acceptable. Please make sure you know the person's name of whom you spoke to.

Osteopathic manipulations are rarely covered by insurance. Please verify your insurance coverage before receiving this procedure.

****

I understand that my insurance policy is a contract between my insurance company and myself. The contract is not between Dr. Berdayes and my insurance company. I know that I am fully responsible for all charges resulting from services rendered to me, including the balance remaining after payment of possible insurance benefits.

However, if payment from your insurance company is not received within 60 days we will notify you of the balance due and your payment is expected in full at that time.

I understand that should my account become delinquent, I will be legally responsible for all cost involved with the collection of this account including all court cost, reasonable attorney fees and all other related cost as allowed under Texas law.

Please sign and date that you understand and agree to our policy.

_____

Print Name

_____

Signature

_____

Date

HIPAA Notice of Privacy Practices

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and disclosures of Protected Health Information

Uses and disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care & treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use & disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Options: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, & conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include; as Required by Law, Public Health Issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration Requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health & Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made ONLY with your Consent, Authorization, or Opportunity to Object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under Federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare options. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request confidential communications from us by alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (ie: electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature: _____ Date: _____

Office Policies

*We ask that you allow up to two weeks for referral requests. Any ***referral*** request made the same day will not be honored. Please schedule your visits to your specialist accordingly.

*All ***calls*** made to the on duty nurse during regular office hours, requiring medical advice that requires more than 5 minutes of phone time, will be billed to your insurance. You are subject to this charge if your insurance does not cover it.

If you *stop by* the office without a scheduled appointment, & ask to speak to the nurse on duty, this will be billed to your insurance as a nurse visit. You are subject to this responsibility if your insurance does not pay and/or your standard office co-pay. ***We do not accept patients on a *walk in* basis***. Please do not walk in to the office & expect to be seen at that time by a physician.

*You need to be on time for all ***appointments***. ***If you are 10 minutes or more late for your appointment, you will not be seen & will have to be rescheduled.*** The doctors make every effort to run on time and we appreciate your cooperation in this matter.

All appointments not cancelled 24 hours in advance will receive a "*no-show*" charge of 25.00. This is an appointment that causes the practice lost revenue, that could have been filled with another patient. Leaving a message with the answering service is not acceptable. For your protection, please make sure you ask the name of the person you have spoken to. If you have 3 no show/no call appointments in a row, we will no longer be able to see you as a patient.

Please do not call for lab, x-ray, scan *results*, etc. before 2 weeks have passed. We do our best to get back to you with your results within 2 weeks. If your labs were ordered STAT, and or if results are critical, we make those phone calls our top priority. A nurse will call you if your results require further action.

*Please be aware of your plans coverage limitations. Things such as osteopathic manipulations, skin tag removals, etc. are rarely covered by insurance. Please verify your insurance coverage before receiving this procedure.

Please allow up to 72 hours for *refill request* to be processed. We strongly advise you to call your refill request into your pharmacy, before you have less than 5 doses left, & have the pharmacy fax us a refill request.

*All ***prescription renewals*** **require a 6 month follow up visit.** Please schedule your visits before you run out of your prescription. We strongly advise you call & schedule your appointment for your med refill appointment, on the same day that you pick up your last refill from your pharmacy.

*If you require a ***prescription refill on a controlled substance***, you will now be required to have your blood pressure & pulse ox, or weight (depending upon the prescription refill you are receiving) checked before picking up your refill in office. This will be billed as a nurse visit to your insurance. You may or may not be responsible for up to $10.00 of this charge, based on what your insurance pays. As always, we ask that you call 5 to 7 days before you run out so that we have time to get it signed by the doctor.
*All prescriptions requiring a ***prior authorization*** will be assessed a $15.00 fee. This will need to be paid in full over the phone or before your next appointment/refill. You may choose to ask the doctor or physician assistant to change your prescription to a generic version of a medicine covered by your insurance, at no charge. However we ask that you contact your pharmacy or insurance to find out what that medication is. Every insurance policy is different & there is no way for us to know whose insurance covers what prescription.

I agree to abide by all office policies listed above.

Printed Name: _____

Signature: _____ Date: _____

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:_____ Date of Birth:_____

Address:_____ Telephone: (____)_____-_____

I hereby authorize:

_____ _____ _____

Name of Provider/Hospital/Physician Provider/Hospital/Physician Address Telephone Number

If I do not specify a period I am authorizing the release of records for entire duration of care with the provider. *(check all that apply below)* Otherwise I am asking to release the following information from my health record covering the period From : _____ To _____ .

☐ Complete Medical Record (includes information regarding insurance, demographic, referral documents, and medical Records). ***If this box is checked, do not check any additional boxes.***

☐ Progress/Office Visit Notes ☐ Radiology/Imaging Reports ☐ Chemotherapy/Radiation Records

☐ Lab Reports ☐ Pathology Reports ☐ Billing/Payment Records

Information is to be released to:
Millennium Physicians
451 Kingwood Medical Drive
Suite #200
Kingwood, Texas 77339
Telephone: (281) 359-2080 Fax: (281) 359-2421

The information is being released for the following purposes:

☐ Continued Care/Treatment ☐ Disability ☐ Attorney/Litigation ☐ Other_____

I understand that this authorization will remain in effect until I revoke it in writing.

I understand that according to applicable state and or/federal laws (Texas Medical Practice Act or Health Insurance Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment

_____ _____ _____

Patient/Legal Representative Print Name Patient/Legal Representative Signature Date

PATIENT ONLINE PORTAL

Millennium Physicians has a Patient Portal you can access online, portal access is free to all Millennium Physician patients. The Patient Portal is an online tool you can use to easily view and update some of your health/clinical information Over the next few months we will be rolling out additional access on the portal that you can utilize such as:

- Appointment Requests
- Reminders
- Prescription Refill Requests
- Communicating Non-Emergent Questions

The Patient Portal should not be used for emergency questions, concerns, or anything that needs a same day response; for all those inquires please contact the office you are seen at.

To gain access to the Patient Portal your email address is required to enroll you; if you would like access please complete the bottom section of this form.

Please check one selection:

____ I would like to be enrolled with Millennium Physicians Patient Portal. My email address is:

_____

(please print)

____ I wish **NOT** to enroll for the Millennium Physicians Patient

Portal because:

( ) I don't have an email address or

( ) I am declining enrollment and do not want to provide my email address.

_____ _____ _____

Patient Signature **Print Name** **Date**