Millennium Physicians
Family Practice

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

Millennium Physicians
Family Practice

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: _____

Millennium Physicians
Family Practice

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

Millennium Physicians Association, PLLC

22710 Professional Drive, Suite 106
Kingwood, Texas 77339
www.millenniumphysicians.com

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Continued next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

- **For Treatment.** We may use or disclose health information about you to provide you with medical treatment. We may disclose health information about you to doctors, nurses, therapists or other Facility personnel who are involved in taking care of you at a Facility. Different departments of a Facility also may share health information about you in order to coordinate your care and provide you medication, lab work and x-rays. We may also disclose health information about you to people outside the Facility who may be involved in your medical care after you leave a Facility, such as through a referral.
- **For Payment.** We may use and disclose health information about you so that the treatment and services you receive at a Facility may be billed to you, an insurance company or a third party. For example, in order to be paid, we may need to share information with your health plan about services provided to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **For Health Care Operations.** We may use and disclose health information about you for our day-to-day health care operations. This is necessary to ensure that all patients receive quality care. For example, we may use health information for quality assessment and improvement activities and for developing and evaluating clinical protocols. We may also combine health information about many patients to help determine what additional services should offer, what services should be discontinued, and whether certain new treatments are effective. Health information about you may be used by our corporate office for business development and planning, cost management analyses, insurance claims management, compliance/risk management activities, and in developing and testing information systems and programs. We may also use and disclose information for professional review, performance evaluation, and for training programs. Other aspects of health care operations that may require use and disclosure of your health information include accreditation, certification, licensing and credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and compliance programs. Your health information may be used and disclosed for the business management and general activities of the Facility including resolution of internal grievances, customer service and due diligence in connection with a sale or transfer of the Facility. In limited circumstances, we may disclose your health information to another entity subject to HIPAA for its own health care operations. We may remove information that identifies you so that the health information may be used to study health care and health care delivery without learning the identities of patients.

OTHER ALLOWABLE USES OF YOUR HEALTH INFORMATION

- **Business Associates.** There are some services provided in our Facility through contracts with business associates. Examples include medical directors; outside attorneys and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- **Providers.** Many services provided to you, as part of your care at our Facility, are offered by participants in one of our organized healthcare arrangements. These participants include a variety of providers such as physicians (e.g., MD, etc.), therapists (e.g., Radiation Therapists, etc.), portable radiology units, clinical labs, hospice caregivers, pharmacies, financial counselor's,), etc.

- **Treatment Alternatives.** We may use and disclose health information to tell you about possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services and Reminders.** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose health information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- **As Required by Law**. We will disclose health information about you when required to do so by federal, state or local law and obtain the proper authorizations to use and disclose information.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.
- **Organ and Tissue Donation.** If you are an organ donor, we may disclose health information to organizations that handle organ procurement to facilitate donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may disclose health information about you as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.
- **Research.** Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. We may, however, disclose health information about you to people preparing to conduct a research project so long as the health information they review does not leave a Facility.
- **Workers' Compensation.** We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Reporting.** Federal and state laws may require or permit the Facility to disclose certain health information related to the following:
  - *Public Health Risks*. We may disclose health information about you for public health purposes, including:
    - Prevention or control of disease, injury or disability
    - Reporting births and deaths;
    - Reporting child abuse or neglect;
    - Reporting reactions to medications or problems with products;
    - Notifying people of recalls of products;
    - Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease;
    - Notifying the appropriate government authority if we believe a resident has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
  - *Health Oversight Activities*. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
  - *Judicial and Administrative Proceedings:* If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
  - *Reporting Abuse, Neglect or Domestic Violence:* Notifying the appropriate government agency if we believe a resident has been the victim of abuse, neglect or domestic violence.
- **Law Enforcement.** We may disclose health information when requested by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;

- About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Facility; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors**. We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.
- **National Security and Intelligence Activities**. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Correctional Institution.** Should you be an inmate of a correctional institution; we may disclose to the institution or its agent's health information necessary for your health and the health and safety of others.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information and give you a copy of it.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the Facility and on the website. The Notice will specify the effective date on the first page, in the top right-hand corner. In addition, if material changes are made to this Notice, the Notice will contain an effective date for the revisions and copies can be obtained by contacting the facility. This Notice of Privacy Practices applies to the following organizations: Millennium Physicians Associations, PLLC, Millennium Oncology, Millennium Radiation, Millennium PET/CT, Millennium Primary Care, Millennium Pulmonary Care, and any other service within Millennium Physicians.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Facility or with the Secretary of the Department of Health and Human Services. To file a formal grievance/compliant against a nurse or physician, please contact the following agencies **(Nurse):** Texas Board of Nursing, 333 Guadalupe Street, Suite 3-460, Austin, Texas 78701, (512) 305-6838. **(Physician):** Texas Medical Board, PO Box 2018, Austin, Texas 78768-2018, (800) 201-0353. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Millennium Physicians Chief Compliance Officer Tomeshia S. Beckett - contact: (281) 359-9935 ext. 2128.

Millennium Physicians
Family Practice

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: _____

Millennium Physicians
Family Practice

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

Millennium Physicians
Family Practice

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**