Millennium Physicians

Dear Patient,

Welcome to Millennium Physicians!

Our goal here at Millennium Physicians is to provide you with the highest level of care and get you back to living life to the fullest.

We want to make your first appointment an easy and pleasant experience. Here are a few reminders about your first appointment:

- Please bring the following items to your new patient appointment:
    - Medical insurance card
    - Driver's license or state id
    - Medical records, we will request your medical records but need authorization. Bring all records you have in your possession as well.
    - Current medication list
    - Allergy list
    - Completed new patient forms
- Please plan to arrive to your appointment 30 minutes prior to your scheduled appointment time, this will allow you complete the new patient paperwork if you have not completed beforehand. The new patient paperwork is located on our website at www.millenniumphysicians.com.
- Please be prepared to spend up to two hours at your first appointment; your first appointment will be a comprehensive visit including a physical exam and review of your medical history. We also want to allow enough time for you to communicate any questions or concerns you may have.
- Be prepared with a list of questions for your physician; this will allow you to effectively communicate all your questions during your appointment.
- We will verify your insurance and obtain any required referrals/authorizations prior to your appointment. In the event we encounter any issues in verifying or obtaining referral/authorization we will contact you prior to the appointment.
- Your copay or patient responsibility will be due at the time of service
- If you have any questions regarding your new patient appointment please contact our new patient coordinators at 1-866-DOCS-MPA (1-866-362-7672)

We look forward to meeting you at your first appointment and taking care of your healthcare needs.

Sincerely,
Millennium Physicians Team

Patient Copy To Keep

Millennium Physicians

PATIENT RIGHTS AND RESPONSIBILITIES

At the Millennium Physicians we respect your rights as a patient, and recognize that you are an individual with unique healthcare needs. We want you to know what your rights are as a patient, as well as what your obligations are to yourself, to other patients, and to your physician.

We encourage a partnership between you and your healthcare team. Your role as a member of this team is to exercise your rights and to take responsibility by asking for clarification of things you do not understand, by following your physician's recommendations and to promptly report any side effects that may occur.

As a patient you have the right …

- To be informed of your rights and responsibility as a patient of Millennium Physicians Association, PLLC.
- To be informed of all rules, regulations, and services provided by the clinic, including the days and hours of service and what to do in an emergency, and clinic telephone numbers.
- To receive care in a safe setting that is free of abuse, neglect, and harassment by physicians and clinic employees.
- To receive considerate and respectful care. We respect your right to:
  - Expect quality treatment within the scope of our mission.
  - Be treated with dignity without discrimination. Your care will not be affected by race, religion, beliefs, cultural values, sex, or age.
  - Choose your own physician.
  - Ask all personnel involved in your care to introduce them-selves, state their role in your care and explain what they are going to do for you.
- To be informed about your treatment and healthcare. Your healthcare team will describe your proposed treatment to you. You can expect the team to explain:
  - A description of our condition and diagnosis.
  - Treatment plan.
  - The alternatives of treatment.
  - The prognosis and any problems related to treatment.
  - Recuperation.
  - The benefit and risks of each treatment option and alternatives.
  - The explanation of risks faced if treatment is not pursued.
- The right to make an informed consent.
- The right to make treatment choices and the right to refuse treatment.

Patient Copy To Keep

Millennium Physicians

PATIENT RIGHTS AND RESPONSIBILITIES

- To be informed of any experimental, investigation, or research activities that involve your treatment. Your healthcare team will:
  - Ask you if you wish to participate in these activities. You have the right to refuse to participate in these activities, or withdraw your previous consent.
- To receive a reasonable estimate of charges for medical care and a payment schedules prior to receiving treatment.
- To have privacy and confidentiality respected. Your healthcare team and clinic staff will:
  - Respect your privacy related to your medical care.
  - Provide confidential treatment of your condition, medical care, medical records, and financial information
- To have access to your personal medical records and obtain copies upon written request.
- To complain or file a grievance with the Clinic Administrator without fear of retaliation or discrimination.

As a patient you have the responsibility to …

- Give the physician and your healthcare team accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about your healthcare.
- Report unexpected changes in your condition to your physician or nurse.
- Inform your physician or nurse of any discomfort/pain and changes in pain.
- Participate in the development of your plan of care, advance directives, and living will.
- Follow the treatment plan and medical directions recommended by your physician and healthcare team.
- Attend all appointments and when unable to do so contact the office 24 hours prior to your appointment to reschedule.
- Follow facility conduct rules, demonstrate good behavior, and assist in maintaining a safe/peaceful environment.
- Report new or changed insurance information, address changes, telephone number changes, email changes, and any other demographic changes to the front desk staff.
- Make sure financial responsibilities are carried out and pay copays/patient responsibility at the time of service.

You have a right to file a formal grievance/complaint against a nurse or physician at 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) 201-9353

Patient Copy To Keep

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

ADVANCE DIRECTIVES INFORMATION SHEET

An **advance directive** is a legal document that tells your family, friends and healthcare professionals the care you would like to have if you become unable to make medical decisions. Through advance directives, you can make legally valid decisions about your future medical treatment.

You do not need a lawyer to complete your advance directives. However, you should be aware that each state has its own laws for creating advance directives.

There are three advance directives recognized in Texas:

- The **Texas Medical Power of Attorney** appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life. Your attending physician must certify in writing that you are unable to make health care decisions and file the certification in your medical record. If you would like more information and a copy of the Texas Medical Power of Attorney form please ask the front desk staff.

- A **living will**, officially known in Texas as the Directive to Physicians and Family or Surrogates, describes the kind of medical treatments or life-sustaining treatments you would want if you were seriously or terminally ill. A living will should be signed, dated and witnessed by two people, preferably individuals who know you well but are not related to you and are not your potential heirs or your health care providers. If you would like more information and a copy of the Directive to Physicians and Family Members form please ask the front desk staff.

- The **Out-of-Hospital Do Not Resuscitate (DNR) order** provides you with the right to withhold or withdraw cardiopulmonary resuscitation (CPR) or other treatments such as defibrillation and artificial ventilation. If you would like more information and a copy of the Texas Department of Health Services Standard Out of Hospital Do Not Resuscitate form please ask the front desk staff.

By creating an advance directive, you are making your preferences about medical care known before you're faced with a serious injury or illness. This will spare your loved ones the stress of making decisions about your care while you are sick. Any person 18 years of age or older can prepare an advance directive.

In order to make your directive legally binding, you must sign it, or direct another to sign it, in the presence of two witnesses who must also sign the document.

It is our responsibility to inform all competent adult patients about Advance Healthcare Directives and ask whether they have one in place. The staff is instructed to know the different types of advance directives. All staff members know where to direct patients who have questions or want more information about advance directives. If a patient provides an advance directive to Millennium Physicians, the physicians and staff should know the patients decisions related to treatment.

Patient Copy To Keep

Millennium Physicians

ADVANCE DIRECTIVES
CONFIRMATION FORM

Under Texas law you have the right to make decisions concerning your healthcare. The rights include the right to accept or refuse medical treatment and the right to create advance directives to make preferences about your medical care. In the state of Texas any person age 18 years or old who is legally competent has the right to make these decisions in advance.

Advance directives recognized in Texas are the Texas Durable Medical Power of Attorney, a Living Will, and an Out of Hospital Do Not Resuscitate. No patient can be discriminated against for exercising their right to elect and create advance directives.

Advance Healthcare Directives Confirmation:

☐ **YES**, I have an Advance Healthcare Directives *(select which advance directive you have below).*

- ☐ Texas Durable Medical Power of Attorney
- ☐ Living Will, officially known as the Directive to Physicians and Family or Surrogates
- ☐ Out of Hospital Do Not Resuscitate (DNR)

If you have selected YES, please provide a copy of your advance directive to the front office staff.

☐ **NO**, I do not have Advance Healthcare Directives *(select which advance directive you have below).* I understand that I can request more information about advance directives.

- ☐ I have received the information sheet about advance directives.
- ☐ I would like additional information about the three advance directives recognized in Texas.

_____ _____

Patient Name (Print) Patient Signature Date

For Millennium Physicians Use Only

Complete this section, if this form is not signed and dated by the patient

____ Patient refused to sign

____ Patient unable to sign

_____ _____

Employee Name Date

TEXAS REGIONAL UROLOGY

Millennium Physicians

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 declining enrollment and do not want to provide my email address.

_____ _____ _____

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

TEXAS REGIONAL UROLOGY

Millennium Physicians

NEW PATIENT MEDICAL QUESTIONNAIRE

Please complete this questionnaire by answering each question as accurately as possible.

GENERAL INFORMATION

Patient Name: _____ Date of Birth:_____ Sex: Male Female

Social Security: _____ - ____ - _____ Insurance Carrier:_____ Insurance ID#:_____

Address: _____ Phone: (____)_____-_____ Cell/Wk: (____)_____-_____

Referring Physician: _____ Primary Care Physician:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Other_____

CHIEF COMPLAINT/REASON FOR VISIT

What is the reason for your visit today? _____

Are you experiencing any pain? (circle one) **YES** **NO** , if yes where is the pain location

_____

If you marked yes, please indicate on the scale of 1 to 10 with 10 being the highest, what is your level of pain **1 2 3 4 5 6 7 8 9 10**

MEDICATIONS

Please list all prescriptions and over-the-counter medication you take on a regular basis. **(If you have a list readily available, please give copy to the front desk)**

Medication Name	Dose (ex. 50mg)	Frequency (ex. once a day)	Reason for Taking

ALLERGIES

Are you allergic to any medications? **YES** **NO** if yes please list medications _____

Are you allergic to intravenous contrast? **YES** **NO** if yes please list your reaction_____

Any other allergies? Incl. Latex **YES** **NO** if yes please list_____

PHARMACY INFORMATION

For our patients convenience we have Millennium Pharmacy in our Kingwood and Woodlands locations, they also deliver to the office you are currently seeing your physician. However, you are can select any pharmacy of your choice. Please select your preferred pharmacy:

☐ MILLENNIUM PHARMACY WOODLANDS (281) 298-1129

☐ MILLENNIUM PHARMACY 2 KINGWOOD (281) 312-8585

☐ OTHER: _____ (___) ____-_____

TEXAS REGIONAL UROLOGY

Millennium Physicians

NEW PATIENT MEDICAL QUESTIONNAIRE

SOCIAL HISTORY

1) Do you or have you EVER used tobacco products? (circle one) **YES** or **NO**, if yes please complete 1A – 1B, in no skip to 2.

1A. Select All That Apply:

- ☐ Current smoker, every day
- ☐ Current smoker, some days
- ☐ Smoker, status unknown
- ☐ Light tobacco smoker
- ☐ Heavy tobacco smoker
- ☐ Former Smoker

1B. Select All That Apply:

- ☐ Cigarettes Amount:_____ per day
- ☐ Cigars Amount:_____ per day
- ☐ Smokeless Amount:_____ per day
- ☐ Pipes Amount:_____ per day

2) Have you had exposure to second hand smoke? (circle one) **YES** or **NO**

3) Do you drink alcoholic beverages? (circle one) **YES** or **NO**, if yes how often _____

FAMILY MEDICAL HISTORY

Please list if any of your family members below have or had any of the following diseases or medical conditions: ***Bleeding/Clotting Disorders, Cancer (list type if known), Diabetes, Heart Disease, Hypertension, Leukemia, Lymphoma, Heart Attack, or stroke.***

Mother:	**Alive**	**Deceased**	Age:_____	Medical Condition:_____
Father:	**Alive**	**Deceased**	Age:_____	Medical Condition:_____
Sister(s):	**Alive**	**Deceased**	Age:_____	Medical Condition:_____
Brother(s):	**Alive**	**Deceased**	Age:_____	Medical Condition:_____
Grandmother:	**Maternal**	**Paternal**	Age:_____	Medical Condition:_____
Grandfather:	**Maternal**	**Paternal**	Age:_____	Medical Condition:_____
Aunts:	**Maternal**	**Paternal**	Age:_____	Medical Condition:_____
Uncles:	**Maternal**	**Paternal**	Age:_____	Medical Condition:_____

PAST MEDICAL HISTORY

1) Have you had any of the following tests within the last 6 months? (Select All That Apply, if yes where and when?)

- ☐ Pet Scan When_____ Where_____
- ☐ CT Scan When_____ Where_____
- ☐ Ultrasound When_____ Where_____
- ☐ Other (specify) When_____ Where_____

2) Have you been hospitalized in the last 6 months? **YES** **NO**
If YES, when_____ and reason for hospitalization _____

3) Please list any prior surgeries: _____

4) Please list any additional information about your medical history that the physician should know:
_____
_____

Millennium Physicians

NEW PATIENT MEDICAL QUESTIONNAIRE

REVIEW OF SYSTEMS

Check the symptoms you currently have or have had in the past year. Please check all that apply.

GENERAL
__ Chills
__ Depression/Nervousness
__ Dizziness/Fainting
__ Excessive Weight Gain or Loss
__ Fever
__ Headache
__ Numbness

CARDIOVASCULAR
__ Chest Pain
__ High/Low Blood Pressure
__ Irregular/Rapid Heart Beat
__ Poor Circulation
__ Shortness Of Breath
__ Swelling In Ankles
__ Varicose Veins

SKIN
__ Any Chronic Rashes Or Eruptions
__ Change In Moles
__ Hives
__ Itching
__ Irregular Scars
__ Poor Healing Of Lesions or Wounds
__ Poor Healing Of Foot Lesions

EYE, EAR, NOSE, & THROAT
__ Bleeding Gums
__ Blurred Vision
__ Crossed Eyes
__ Difficulty Swallowing
__ Double Vision
__ Earache Or Ear Discharge
__ Hay Fever
__ Hoarseness
__ Loss of Hearing
__ Nosebleeds
__ Persistent Cough
__ Ringing In Ears
__ Sinus Problems
__ Vision – Flashes or Halos

GASTROINTESTINAL
__ Bloating
__ Black Or Tarry Stools
__ Bowel Changes
__ Change In Appetite
__ Constipation
__ Diarrhea
__ Excessive Thirst
__ Gas
__ Hemorrhoids
__ Indigestion/Heartburn
__ Nausea
__ Rectal Bleeding
__ Stomach Pain
__ Vomiting

HEMATOLOGIC
__ Anemia
__ Easy Bruising
__ Excessive Bleeding

RESPIRATORY
__ Chronic Cough
__ Coughing Up Blood
__ Wheezing Or Asthma

URINARY
__ Blood In Urine
__ Frequent Urination
__ Lack Of Bladder Control
__ Painful Urination

NEUROLOGICAL
__ Double Vision/Vision Loss
__ Prior Stroke
__ Muscular Weakness/Tingling
__ Speech Difficulty
__ Transient Paralysis
__ Transient Neurologic Deficit

MUSCLE/BONE/JOINT
Pain, Weakness, Numbness In:
__ Arms
__ Back
__ Feet
__ Hands
__ Hips
__ Legs
__ Neck/Shoulders

MEN ONLY
__ Erection Difficulties
__ Lump In Testicles
__ Penis Discharge
__ Sore On Penis
__ Other
Issue_____

Other
_____
_____
_____
_____
_____
_____
_____

Texas Regional Urology

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NEW PATIENT MEDICAL QUESTIONNAIRE

REVIEW OF SYSTEMS CONTINUED

Check all the conditions you have or have had in the past.

__ Aids __ Appendicitis __ Arthritis __ Asthma __ Bleeding Disorders __ Breast Lump __ Cancer __ Cataracts __ Chemical Dependency	__ Chicken Pox __ Diabetes __ Emphysema __ Epilepsy __ Glaucoma __ Heart Disease __ Hepatitis __ Herpes __ High Cholesterol	__ HIV Positive __ Kidney Disease __ Liver Disease __ Measles __ Migraine Headaches __ Multiple Sclerosis __ Mumps __ Pacemaker __ Pneumonia	__ Polio __ Prostate Problem __ Rheumatic Fever __ Scarlet Fever __ Stroke __ Thyroid Problems __ Tuberculosis __ Ulcers __ Venereal Disease

Women Only

__ Abnormal Pap Smear
__ Bleeding Between Periods
__ Breast Lump
__ Extreme Menstrual Pain
__ Hot Flashes
__ Nipple Discharge
__ Painful Intercourse
__ Vaginal Discharge

Date of Last Period: _____
Age at first Period: _____
Date of Last Pap Smear: _____
Date of Last Mammogram:_____
Prior Breast Biopsies? Yes or No
Prior Breast surgery? Yes or No

Are you currently pregnant? Yes or No
Number of children: _____
Age when first child was born: _____
Did you breast feed? Yes or No
If so, how long: _____
Are you currently or ever taken contraceptive? Yes or No
If so, how long? _____

Post-Menopausal Women Only

Age at menopause:_____
Have you ever taken hormone replacement therapy? Yes or No
If yes, for how many months/years:_____

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I ever have a change in health.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Print Name of Patient or Personal Representative **Relationship to Patient**

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ALCOHOL MISUSE/ABUSE (AUDIT C)

Name: _____ Gender: _____ Date: _____

Did you have a drink containing alcohol in the past year?
__ Yes
__ No

If 'Yes': How often did you have a drink containing alcohol in the past year?
__ Never (0 point)
__ Monthly or less (1 point)
__ 2 to 4 times a month (2 points)
__ 2 to 3 times a week (3 points)
__ 4 or more times a week (4 points)

If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year?
__ 1 or 2 drinks (0 point)
__ 3 or 4 drinks (1 point)
__ 5 or 6 drinks (2 points)
__ 7 to 9 drinks (3 points)
__ 10 or more drinks (4 points)

If 'Yes': How often did you have 6 or more drinks on one occasion in the past year?
__ Never (0 point)
__ Less than monthly (1 point)
__ Monthly (2 points)
__ Weekly (3 points)
__ Daily or almost daily (4 points)

Total Points: _____

Interpretation
__ Positive
__ Negative

Interpretation
The AUDIT-C is scored on a scale of 0-12 (scores 0 reflect no alcohol abuse)

- In men, a score of 4 or more is considered positive.
- In women, a score of 3 or more is considered positive.

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PRIOR AUTORIZATION FOR ANY PRESCRIBED MEDICATIONS

Please note, if we write any medications that are rejected by your insurance company, we will no longer submit a "prior authorization." It will be your responsibility to contact your insurance company to determine what medications are on their formulary list.

I fully understand and am aware that I should contact my insurance company and to call back with a list of medicines that are approved by my insurance company.

_____ _____

Printed Name DOB

_____ _____

Patient Signature Date

TEXAS REGIONAL UROLOGY

Millennium Physicians

PATIENT CANCELLATION POLICIES

Office Visit Cancellation:

We require a 24-hour notice of cancellation for office visit appointments. If not notified timely, there will be a **$25.00 NO SHOW** fee assessed to your account.

Office Procedure Cancellation:

A 24-hour notice is also required to cancel procedures. Failure to provide timely notice will result in either a **$50.00 NO SHOW** fee assessment to your account or retention of the deposit collected in advance; i.e. **$75/UDS, $100/VAS.**

Surgery Cancellation

Surgery scheduling involves a significant amount of work with coordination of multiple disciplines including physician, nursing, administration, insurance, medical suppliers, and the facility.

Because cancellation can result in unused operative resources, we require a minimum of 72 hours (3 business days) notification should you need to cancel your surgery. This allows the physician/facility ample time to schedule another patient. Failure to notify us of cancellation in the required time will result in a **$250.00** charge assessed to your account.

If you must cancel your surgery, please call (281) 290-9800

All cancellation fees must be paid prior to rescheduling your appointment or surgery. Exceptions to this policy will be made at the discretion of your physician for emergencies and conflicts beyond your control.

****

I have read this policy and understand the cancellation fees as outlined.

_____ _____

Printed Name DOB

_____ _____

Patient Signature Date

TEXAS REGIONAL UROLOGY

Millennium Physicians

GENERAL CONSENT FOR TREATMENT AND ACKNOWLEDGEMENT

MEDICAL CONSENT: I consent to all medical care, treatment, laboratory, imaging and other medical procedures performed or prescribed by a physician of Millennium Physicians and his/her designees as directed in his/her judgement.

RIGHT TO REFUSE TREATEMENT: I understand that I have the right to make informed decisions regarding all my care and treatments, and that I should ask my health care professional to further clarify or explain anything I do not understand. This right includes the right to refuse any treatments that I do not want.

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT RIGHTS & NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received both notices, Notice of Patient Rights/Responsibilities and Notice of Privacy Practices.

ADVANCE DIRECTIVES: I understand that I have an opportunity to make known my wishes, in writing regarding my health care and/or end of life decisions. This directive is in the form of a living will and/or durable power of attorney for health care.

RELEASE OF MEDICAL INFORMATION: I authorize Millennium Physicians Association, PLLC to release any information necessary to facilitate healthcare processing of claims, and audit of payments relative to my care/treatment with Millennium Physicians. I also consent to the release of any information as needed for my care to other facilities, agencies, or healthcare providers as I direct or as required by law. This order will remain in effect until revoked by me in writing.

FINANCIAL AGREEMENT: I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists. I understand I am financially responsible to Millennium Physicians for charges not paid under this agreement. I am responsible for all charges for services provided to me which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. Millennium Physicians will make every attempt to notify me in advance if a service is not covered. I agree to pay all applicable co-payments, deductibles, and co-insurance. I am responsible to pay all copays, deductibles, and patient responsibility at the time of service unless other arrangements have been made in advance.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Medigap, Medicare Replacement, private insurance and any other health / medical plan, to issue payment check(s) directly to **Millennium Physicians Association, PLLC** for medical services rendered to myself. I understand that I am responsible for any amount not covered by insurance.

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorized any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. (Consent applies only when applicable.)

By signing below, I acknowledge that I have read, understand, and agree to the terms and conditions of this form and that I am authorized as the patient or the Patient's Legal Representative to sign this document.

_____	_____	_____
Patient /Legal Representative Name (Print)	Patient/Legal Representative Signature	Date

For Millennium Physicians Use Only

Complete this section, if this form is not signed and dated by the patient or patient's legal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Millennium Physicians Notice of Privacy Practices but was unable to do so for the following reason:

____ Patient refused to sign ____ Patient unable to sign ____ Other Reason (Describe):_____

_____	_____
Employee Name	Date

TEXAS REGIONAL UROLOGY

Millennium Physicians

PATIENT AUTHORIZATION
TO COMMUNICATE AND DISCLOSE PROTECTED HEALTH INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means or communicated to authorized designated parties including family members.

I wish to be contacted in the following manner *(Check All That Apply):*

☐ **Home Telephone**
- ○ Leave message with detailed information.
- ○ Only leave message with call back details.

☐ **Work Telephone**
- ○ Leave message with detailed information.
- ○ Only leave message with call back details.

☐ **Cell Telephone**
- ○ Leave message with detailed information.
- ○ Only leave message with call back details.

☐ **Written Correspondence**
- ○ Mail to my home address on file.
- ○ Mail to my work/office address:

_____

_____

I hereby authorize one or all of the designated parties below to request, discuss, and receive any protected health information regarding my healthcare and treatment. This PHI includes my treatment information, billing, payments, or any information in my medical records. I understand that the identity of designees must be verified before release of PHI.

Authorized Designees:

Name:_____ Relationship:_____ Telephone: (____)_____-_____

Name:_____ Relationship:_____ Telephone: (____)_____-_____

Name:_____ Relationship:_____ Telephone: (____)_____-_____

Name:_____ Relationship:_____ Telephone: (____)_____-_____

This authorization shall remain in effect from the date signed below until revoked.
You have the right to revoke this authorization in writing.

- ***I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.***
- ***I understand information disclosed to any above designees is no longer protected by federal or state law and may be subject to re-disclosure by the above designee.***

_____ _____ _____

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

☐ **REVOKE/CANCEL THIS AUTHORIZATION**

_____ _____

Patient/Legal Representative Signature | Date

Texas Regional Urology

Millennium Physicians

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

To release the following information from my health record covering the period of From_____ to_____, 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)*

☐ 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 _____ Telephone: (____)_____-_____ Fax: (____)_____-_____

Office Address

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

☐ **REVOKE/CANCEL THIS AUTHORIZATION**

_____ _____

Patient/Legal Representative Signature Date

TEXAS REGIONAL UROLOGY