



PATIENT INFORMATION			
First Name:	Last Name:	Maiden Name:	Date of Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Select One: <input type="checkbox"/> Full Time Resident (Year Round) <input type="checkbox"/> Winter Resident (Oct – Apr) <input type="checkbox"/> Summer Resident (May – Sep)			
Street Address:		SS#:	
City, State, Zip:		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Home Phone	Cell Phone	Work Phone	Preferred Language:
Referring Physician:		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Non-Latino	
Race:			
<input type="checkbox"/> American Indian or Alaska Native _____		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander _____	
<input type="checkbox"/> Asian _____		<input type="checkbox"/> Other Race _____	
<input type="checkbox"/> Black or African American _____		<input type="checkbox"/> White _____	
EMERGENCY CONTACTS			
Name:	Relationship:	Phone:	Cell Phone:
Name:	Relationship:	Phone:	Cell Phone:
Name:	Relationship:	Phone:	Cell Phone:
GUARANTOR (if other than patient):			
Name:	Relationship:		
Street Address:		City, State, Zip:	
Home Phone:	Work Phone:	Cell Phone:	
PRIMARY INSURANCE or MEDICARE		SECONDARY INSURANCE	
<input type="checkbox"/> Same as Patient <input type="checkbox"/> Same as Guarantor <input type="checkbox"/> Other		<input type="checkbox"/> Same as Patient <input type="checkbox"/> Same as Guarantor <input type="checkbox"/> Other	
PLEASE HAVE YOUR INSURANCE CARD(S) AVAILABLE TO BE PHOTOCOPIED FOR YOUR FILE!			
To improve interactions and communications with our patients, we have implemented automated systems for phone messages and for email communications concerning appointment reminders, past due balance alerts, and disease management initiatives, etc.			
May we place automated phone calls or email messages with you? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please indicate preferences below:			
Health Notifications	Appointment	Announcements	Billing Information
<input type="checkbox"/> Email	<input type="checkbox"/> Email <input type="checkbox"/> Phone	<input type="checkbox"/> Email <input type="checkbox"/> Phone	<input type="checkbox"/> Email <input type="checkbox"/> Phone
Email Address:		How did you hear about us?	
		<input type="checkbox"/> TV <input type="checkbox"/> Radio <input type="checkbox"/> Newspaper <input type="checkbox"/> Friend <input type="checkbox"/> Physician	

ASSIGNMENT AND RELEASE:

- I hereby assign my insurance benefits to be paid directly to Millennium Physician Group.
- I agree to be solely responsible for all collection fees, attorney fees, and court costs necessary to collect payment on any portion of the delinquent balance, and, I hereby authorize MPG to conduct any and all financial investigative reports that they deem necessary to determine if service is to be provided and if any payment arrangements can be made.
- I understand that if I fail to cancel or reschedule an appointment, I may be charged a "No Show" fee.
- I authorize the physician to release any medical information required to process the claim.
- I authorize electronic communications from MPG for healthcare maintenance purposes (i.e., emails, phone calls, and MPG-Communicator Portal messages).

Signature: _____

Date: _____



PLEASE READ CAREFULLY

Our commitment is to provide the very best healthcare to you, our patient. Your clear understanding of- and agreement to- our financial policies concerning your medical care is fundamental to our professional relationship with you. Should you have additional questions about our fees and financial policies, or about your responsibilities relating to your insurance coverage, please contact the Practice Manager.

PROFESSIONAL FEES: Our prices are representative of the usual and customary charges for our area. Our fees reflect the Provider's time dedicated to your care. That time includes the review of any prior medical records, diagnostic testing, authorizations and other insurance requirements as well as the coordination of your care with other physicians involved in your health care planning.

INSURANCE PAYMENTS: We participate in assignment of payment with specific insurance plans in the State of Florida. Your insurance coverage is a contract between you and your insurance plan. It is your responsibility to verify and know your insurance benefit coverage including your out of pocket requirements. If your insurance plan is one with which we participate and If you have provided valid proof of insurance for that plan, we will submit your claim(s) as a courtesy to you, our patient.

PROOF OF INSURANCE: Before being seen by a Provider, you must complete the Patient Information Form; provide a driver's license or legal identification card; and, provide a current valid insurance card as proof of insurance. If the insurance information you provide is incorrect, you will be responsible for the balance of the claim.

PATIENT PAYMENTS/SELF-PAY BALANCES: Your co-payments and deductibles, services not covered by your insurance plan, and self-pay balances are due at the time of your appointment. Your balances are due upon receipt of the Millennium Physician Group statement unless you have made other arrangements prior to the service being rendered. You may pay by cash, check or credit card. We accept Visa, MasterCard, Discover and American Express and encourage you to utilize the "Credit Card on File" program for easy and convenient balance resolution. After 90 days of non-payment, your account may be turned over to a collection agency.

APPOINTMENTS: Please understand that your appointment is time that has been reserved for your health care needs. If you are running late, please call us as soon as possible; if you need to cancel your office and/or procedure appointment, **please call us 24-hours in advance**. If you fail to show up for a scheduled office appointment, you may be assessed a \$50 No Show fee that will be due on your next office visit.

NON-COVERED SERVICES: Some services you receive may be non-covered or may be considered not necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.

MEDICARE BENEFICIARIES: Medicare will sometimes limit coverage of certain goods or services based on the diagnosis or the frequency in which they are performed. In the event that your provider identifies the potential for denial of your claim for either of these reasons, in accordance with Medicare requirements, you will be asked to complete an Advanced Beneficiary Notification Form (ABN) which will provide you the opportunity to be given the expected cost to you for the services - prior to services being rendered. You will be able to elect to receive the services and be responsible for the cost Medicare assigns, or, elect to decline the services.

COLLECTION AGENCIES: If it becomes necessary to place your account with a third party collection agency due to non-payment, you may be discharged from our Practice. Should this occur, we will treat you on an emergency basis only for the next 30 days while you find alternative medical care.

BOUNCED CHECKS: A \$50 charge will be applied for each check returned by your bank. If you have had more than one bounced check, your Provider may elect to not accept future checks from you.

YOUR SIGNATURE ON THIS PAGE CONSTITUTES AN AGREEMENT TO THIS POLICY.

I have read and agree to the above Financial Policies and Information. I hereby assign all medical and/or surgical benefits to which I am entitled through my insurance - governmental or private - to Millennium Physician Group, LLC. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is considered as valid as the original.

Printed Name of Patient: _____ Patient's D.O.B.: _____

Signature of Person Responsible for the Account

Printed Name of Person Responsible for Account

Date



Collier County
Patient Representative Authorization

COMPLETE ALL SECTIONS OF THIS DOCUMENT BECAUSE INCOMPLETE FORMS WILL NOT BE PROCESSED																							
Patient Name: _____	Patient Date of Birth: _____																						
<input type="checkbox"/> I DO NOT WANT TO NAME A PATIENT REPRESENTATIVE AT THIS TIME.																							
Patient Signature: _____ Date: _____																							
<p>I, _____, HEREBY AUTHORIZE DR. _____ (OR HIS/HER AGENT) TO DISCUSS MY CARE/CONDITION WITH THE FOLLOWING PERSON(S):</p> <table style="width:100%; border: none;"> <tr> <td style="width: 50%; border: none;">Name: _____</td> <td style="width: 50%; border: none;">Name: _____</td> </tr> <tr> <td style="border: none;">Address: _____</td> <td style="border: none;">Address: _____</td> </tr> <tr> <td style="border: none;">City/State/Zip: _____</td> <td style="border: none;">City/State/Zip: _____</td> </tr> <tr> <td style="border: none;">Relationship: _____</td> <td style="border: none;">Relationship: _____</td> </tr> <tr> <td style="border: none;">Phone #: _____</td> <td style="border: none;">Phone #: _____</td> </tr> </table>		Name: _____	Name: _____	Address: _____	Address: _____	City/State/Zip: _____	City/State/Zip: _____	Relationship: _____	Relationship: _____	Phone #: _____	Phone #: _____												
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Relationship: _____	Relationship: _____																						
Phone #: _____	Phone #: _____																						
Medical information discussed / disclosed may include (check all that apply): <input type="checkbox"/> Alcohol and/or Drug Abuse <input type="checkbox"/> Sexual Transmitted Disease (STD) <input type="checkbox"/> Mental Health <input type="checkbox"/> Not Applicable <input type="checkbox"/> Acquired Immunodeficiency Syndrome (AIDS) <input type="checkbox"/> Human immunodeficiency Virus (HIV) infection																							
<p><i>This authorization to discuss/disclose private health information to the designated person(s) named above shall remain in effect for one year from the date of this signed release unless and until I have revoked the authorization by sending written notification to my HealthCare Provider at Millennium Physician Group, LLC / Medical Records Dept. (select appropriate facility):</i></p> <table style="width:100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> 5490 Bryson Dr., #201, Naples, FL 34109</td> <td style="width: 50%; border: none;"><input type="checkbox"/> 501 Goodlette Rd., #100A, Naples, FL 34102</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 1735 SW Health Pkwy, Naples, FL 34109</td> <td style="border: none;"><input type="checkbox"/> 11181 Health Park Blvd., #3000, Naples, FL 34110</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 8803 Tamiami Tr., East, Naples, FL 34113</td> <td style="border: none;"><input type="checkbox"/> 6610 Willow park Dr., #101, Naples, FL 34109</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 1495 Pine Ridge Rd., #4, Naples, FL 34109</td> <td style="border: none;"><input type="checkbox"/> 400 8th Street N, Naples, FL 34102</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 681 Goodlette Rd., #130, Naples, FL 34102</td> <td style="border: none;"><input type="checkbox"/> 606 Bald Eagle Dr., #302, Marco Island, FL 34145</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 800 Goodlette Rd., #200, Naples, FL 34102</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 681 Goodlette Rd., #340, Naples, FL 34102</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 11181 Health Park Blvd., #3030, Naples, FL 34110</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 11181 Health Park Blvd., #3010, Naples, FL 34110</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 700 2nd Ave. N., #205, Naples, FL 34102</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 5671 Naples Blvd., Naples, FL 34109</td> <td style="border: none;"></td> </tr> </table>		<input type="checkbox"/> 5490 Bryson Dr., #201, Naples, FL 34109	<input type="checkbox"/> 501 Goodlette Rd., #100A, Naples, FL 34102	<input type="checkbox"/> 1735 SW Health Pkwy, Naples, FL 34109	<input type="checkbox"/> 11181 Health Park Blvd., #3000, Naples, FL 34110	<input type="checkbox"/> 8803 Tamiami Tr., East, Naples, FL 34113	<input type="checkbox"/> 6610 Willow park Dr., #101, Naples, FL 34109	<input type="checkbox"/> 1495 Pine Ridge Rd., #4, Naples, FL 34109	<input type="checkbox"/> 400 8 th Street N, Naples, FL 34102	<input type="checkbox"/> 681 Goodlette Rd., #130, Naples, FL 34102	<input type="checkbox"/> 606 Bald Eagle Dr., #302, Marco Island, FL 34145	<input type="checkbox"/> 800 Goodlette Rd., #200, Naples, FL 34102		<input type="checkbox"/> 681 Goodlette Rd., #340, Naples, FL 34102		<input type="checkbox"/> 11181 Health Park Blvd., #3030, Naples, FL 34110		<input type="checkbox"/> 11181 Health Park Blvd., #3010, Naples, FL 34110		<input type="checkbox"/> 700 2 nd Ave. N., #205, Naples, FL 34102		<input type="checkbox"/> 5671 Naples Blvd., Naples, FL 34109	
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<input type="checkbox"/> I understand that I have the right to inspect the medical records requested and that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by State or Federal Law.																							
PATIENT _____ (Printed Name)	PATIENT _____ DATE _____ (Signature, or parent/legal guardian signature if patient is minor)																						
<input type="checkbox"/> I would like to have copy of this authorization for my personal files.																							

Patient Name: _____ ID# _____ D.O.B.: _____ TODAY'S DATE: _____

PATIENT'S CARE TEAM					
	Name/Specialty		Address		Phone
Primary Care Physician					
Specialists					
PHARMACY					
	Location/Address			Phone # (if known)	
Preferred Pharmacy (local)					
Preferred Pharmacy (mail away)					
MEDICATIONS: include herbal remedies, vitamins, frequent over-the-counter meds (aspirin, ibuprofen, Tylenol, Tums, etc.)					
Name	Dose-mg		Directions		
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
ALLERGIES					
Are you allergic to Contrast Dye? <input type="checkbox"/> YES <input type="checkbox"/> NO					
Allergic to:		Reactions:			
1.					
2.					
3.					
4.					
5.					
6.					
IMMUNIZATION					
Name:	Given:	Date:	Name:	Given:	Date:
Flu			Tetanus		
Pneumonia			Hepatitis		
Zostivax (shingles)			Other		

Patient Name: _____ ID# _____ D.O.B.: _____ TODAY'S DATE: _____

PAST MEDICAL HISTORY PLEASE CHECK ALL THAT APPLY		SURGICAL HISTORY PLEASE LIST ALL SURGERIES/PROCEDURES AND YEAR	
<input type="checkbox"/> Alcohol Overuse	<input type="checkbox"/> Hepatitis	1.	
<input type="checkbox"/> Allergies (other than meds)	<input type="checkbox"/> High Blood Pressure	2.	
<input type="checkbox"/> Amputation (location)	<input type="checkbox"/> High Cholesterol	3.	
<input type="checkbox"/> Anemia	<input type="checkbox"/> HIV / AIDS	4.	
<input type="checkbox"/> Anxiety/Stress	<input type="checkbox"/> Hormone Replacement	5.	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hospitalizations Other than operations	6.	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Jaundice	7.	
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Kidney Disease	8.	
<input type="checkbox"/> Barretts' Esophagus	<input type="checkbox"/> Kidney Stones	9.	
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Measles / Mumps	10.	
<input type="checkbox"/> Blood Thinner Treatment	<input type="checkbox"/> Memory Loss / Alzheimer's	11.	
<input type="checkbox"/> Cancer (location)	<input type="checkbox"/> Nerve Damage / Neuropathy	12.	
<input type="checkbox"/> Cardiac Arrhythmias/ Irregular Heart Rate	<input type="checkbox"/> Nervous Breakdown	Do you have a Pace Maker? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> Cardiac Pacemaker / DeFib	<input type="checkbox"/> Osteopenia / Osteoporosis	HEALTH MAINTENANCE PLEASE LIST DATE OF LAST EXAM	
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Ostomies (location)		Year
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Other	Stress Test	
<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Paralysis	Echocardiogram	
<input type="checkbox"/> Colon Problems	<input type="checkbox"/> Parkinson's	EKG	
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Prostate Problems	Chest X-Ray	
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Rash/Skin Condition	Mammogram	
<input type="checkbox"/> Depression	<input type="checkbox"/> Rheumatic Fever	Pap Smear	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures	PSA	
<input type="checkbox"/> Emphysema / COPD	<input type="checkbox"/> Serious Injuries	Bone Density	
<input type="checkbox"/> Erectile/Sexual Dysfunction	<input type="checkbox"/> Sexually Transmitted Dis.	Colonoscopy	
<input type="checkbox"/> Falls	<input type="checkbox"/> Sleep Disorder / Insomnia		
<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Stroke / TIA		
<input type="checkbox"/> Gastritis	<input type="checkbox"/> Thyroid Disease		
<input type="checkbox"/> GERD / Ulcer	<input type="checkbox"/> Urinary problems		
<input type="checkbox"/> Gout	<input type="checkbox"/> Vascular Disease		
<input type="checkbox"/> Headaches / Migraines	<input type="checkbox"/> Vision Problems		
<input type="checkbox"/> Heart Disease / Heart Attack	<input type="checkbox"/>		

Patient Name: _____ ID# _____ D.O.B.: _____

FAMILY HISTORY: Check all that apply if a blood relative (parent, sibling, child) has any of the following and indicate which relative applies.			
<input type="checkbox"/> Do not know Family History	<input type="checkbox"/> Mother is Living <input type="checkbox"/> Mother is Deceased Age of Death: _____ Cause of Death: _____	<input type="checkbox"/> Father is Living <input type="checkbox"/> Father is Deceased Age of Death: _____ Cause of Death: _____	
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Other
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/>
<input type="checkbox"/> Colon/Rectal Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Skin Cancer	<input type="checkbox"/>
<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/>
<input type="checkbox"/> Depression	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Suicide	<input type="checkbox"/>
SOCIAL HISTORY:			
Occupation: _____		Retired: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single		# of Children _____	
<input type="checkbox"/> Widow/Widower <input type="checkbox"/> Divorced		# of Pregnancies _____	
Alcohol: <input type="checkbox"/> Yes <input type="checkbox"/> No	Smoke: <input type="checkbox"/> Yes <input type="checkbox"/> No	Exercise <input type="checkbox"/> Yes <input type="checkbox"/> No	Illicit Drug Use <input type="checkbox"/> Yes <input type="checkbox"/> No
Type: _____	Frequency: # _____ Pack/Day # _____	Type: _____	<input type="checkbox"/> Marijuana
Frequency: _____	Number of Years _____	Frequency: _____	<input type="checkbox"/> IV Drug use
Number of Drinks _____	Quit Date: _____	Number of Drinks _____	
<input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month		<input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month	
<p><i>I hereby authorize Millennium Physician Group to obtain for my medical records any medication history that is automatically downloaded from the Pharmacy Benefits Manager through SureScripts.</i></p> <p style="text-align: center;">Patient Signature:</p>			
<p><i>I hereby authorize Millennium to disclose my medical records and health care information to other medical providers and facilities upon their request in connection with my medical care and treatment.</i></p> <p style="text-align: center;">Patient Signature:</p>			
<p><i>I hereby authorize Millennium to exchange my immunization history with the Florida Immunization Registry.</i></p> <p style="text-align: center;">Patient Signature:</p>			