



Welcome to Millennium Medical Management the home of...
Deuk Spine Institute, Viera Orthopedic, Urgent Ortho Care
and *Viera Health & Wellness.*
Enclosed you will find a map to our offices. We look forward to seeing you!

Please remember

___ Bring a completed packet to your appointment.

___ Bring your most current insurance card(s) including secondary insurance and a photo id.

___ Bring films or CDs with reports pertinent to your visit that were done in the last six months. (MRIs, X-rays, CT scans)
You may need to go to the facility to pick them up.

___ Bring a current list of medications including dosage.

Appt Date _____ Time _____
Please arrive 30 minutes prior to your scheduled appointment time.
 Viera **Titusville**

Titusville Office

836 Century Medical Dr. Titusville, FL 32796-2141 (321) 383-8092 Fax (321) 383-1043

Viera/Melbourne Office

7955 Spyglass Hill Rd., Ste. A, Melbourne, FL 32940-8249 (321) 255-6670 Fax (321) 242-2545

Things to Know About Our Office

We collect insurance deductibles, co-pays and coinsurances upon check in:
Check or credit card only. **No Cash**, please.

Please allow 24 to 48 hours for all prescription refill requests.
Some prescriptions cannot be called into the pharmacy, but can be picked up at our office.

Our normal office hours are Monday through Friday 8am to 5pm.

Office Maps
Titusville Office

836 Century Medical Dr. Titusville, FL 32796



From I-95 take the **SR-406** exit, **EXIT 220**, toward **Titusville / Historic District**.

go **0.3 mi**



Go **East** onto **SR-406 E / Garden St.**

go **2.1 mi**



Turn **left** onto **Park Ave N.**

*Park Ave N is just past Dixie Ave N
 If you reach Grannis Ave N you've gone a little too far*

go **0.2 mi**



Turn **right** onto **Draa Rd.**

go **0.03 mi**



Turn **left** onto **Norwood Ave.**

go **0.2 mi**



Take the 2nd **right** to stay on **Norwood Ave.**

Norwood Ave is 0.1 miles past Shady Pines Ln

go **0.03 mi**



Turn **left** onto **N Washington Ave / US-1 N / SR-5 N.**

go **0.3 mi**



Take the 1st **right** onto **Buffalo Rd.**

*Buffalo Rd is 0.1 miles past Malinda Ln
 Mobile Gas Station will be on the South East corner
 If you reach Medical Dr you've gone about 0.1 miles too far*

go **0.1 mi**



Take the 1st **left** onto **Century Medical Dr.**

If you reach the end of Buffalo Rd you've gone about 0.2 miles too far

go **0.1 mi**



Turn **slight left** to stay on **Century Medical Dr.**

go **0.02 mi**



Turn **left** to stay on **Century Medical Dr.**

go **0.04 mi**



836 CENTURY MEDICAL DR is on the **left**.

Follow road around the loop we are on the North East side of the loop.



VIERA OFFICE
7955 Spyglass Hill Rd. Suite A, Melbourne, Fl. 32940



From I-95 take the **CR-509 / Wickham Road** exit, **EXIT 191**, toward **Satellite Beach / Patrick A.F.B.**. go **0.3 mi**



Go **East** onto **CR-509 S / Wickham Rd N**. go **0.4 mi**



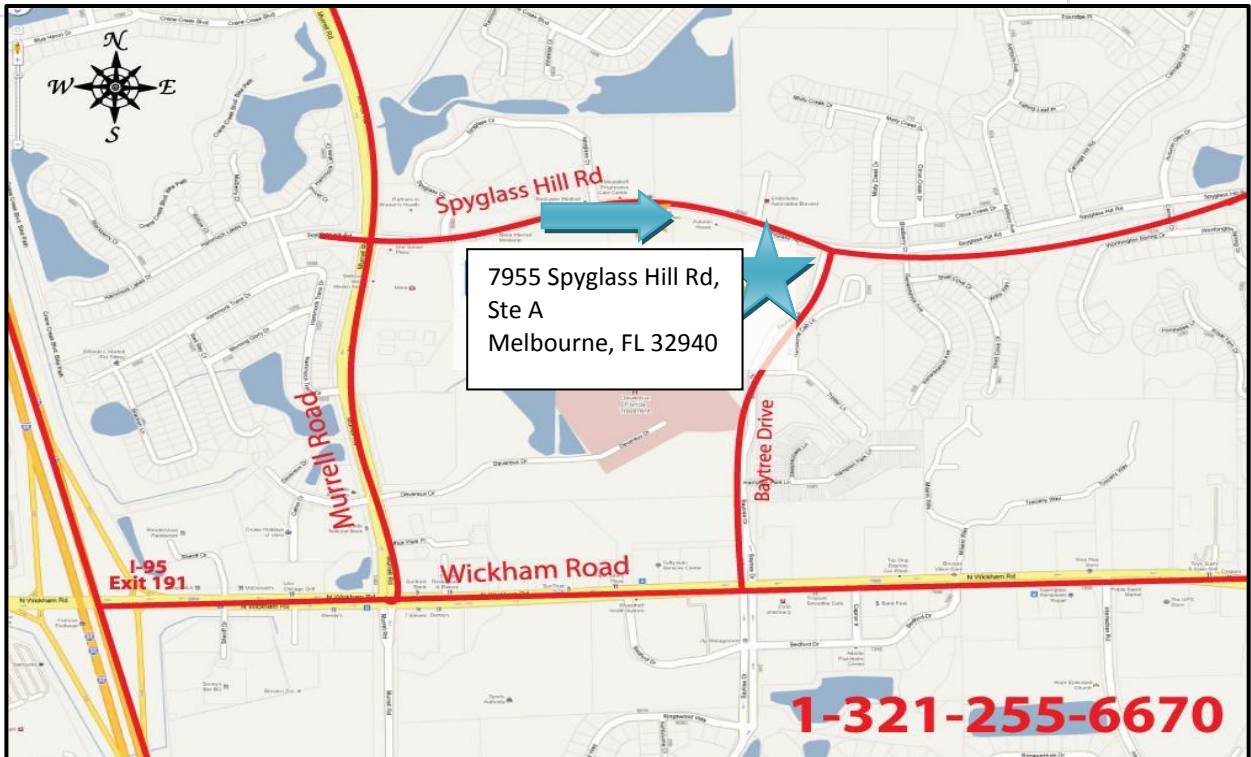
Turn **left** onto **Murrell Rd**. go **0.5 mi**
Murrell Rd is 0.1 miles past Sheriff Dr
Uno Chicago Grill is on the North West corner of the intersection
If you are on Wickham Rd N and reach Office Park Pl you've gone about 0.1 miles too far



Take the 3rd **right** onto **Spyglass Hill Rd**. go **0.2 mile**
Spyglass Hill Rd is 0.2 miles past Hammock Trace Dr
MIMA is on the South East corner of the Intersection
If you reach Crane Creek Blvd you've gone about 0.3 miles too far



7955 Spyglass Hill Rd Suite A is on the right. Eff. 4/22/14
Your destination is 0.1 miles past Spyglass Ct
3rd driveway on the right, parking lot go left then first right, follow around to the back
far right corner behind Heart & Sol Ob/GYN
If you reach Classic Ct you've gone about 0.2 miles too far





Patient Name: _____ Date of Birth: _____

Dear Patient:

What to expect on your first visit... During your appointment here at Millennium Medical Management you will meet a number of staff members.

First you will be greeted by the **Front Office** staff who will take your personal information pertaining to your visit. This may include identification, insurance information, medical records and any x-rays, MRI's, or other diagnostic studies that you might have. Please arrive 30 minutes prior to your first appointment with your packet of new patient forms filled out. The Front Office staff may have a few additional questions or forms for you. It is especially important for you to arrive early if you are the first patient of the day or the first patient after lunch.

You will then be escorted to a room by a **Medical Assistant**. Our Medical Assistants have advanced training above and beyond that usually found in typical clinics. Millennium Medical Management advanced Medical Assistants have additionally earned the title of "**Patient Navigator**". This means that in addition to advanced training, they have experience in "navigating" patients through often complicated issues involving medical records, HIPAA regulations, scheduling tests, procedures and appointments.

The Medical Assistants, under direct supervision of our physicians, will take your blood pressure, heart rate, weight and record your level of pain at the time of the visit. We have created in-depth questionnaires that the Medical Assistants will go over with you that are an important part in your plan of care. Please cooperate with them as they are trying to provide the physician with the most pertinent information for your care.

Our Medical Assistants will assist Millennium Medical Management physicians and Physician Assistants in basic parts of the examination including testing strength, balance and coordination. The physician and/or Physician Assistant will test their findings with the patient and perform additional examination as necessary.

Next you may meet the **Physician Assistant** or **Nurse Practitioner** who is licensed by the State of Florida to practice medicine and advanced nursing under the supervision of Millennium Medical Management physicians. These PAs and NPs assist with surgeries, perform exams, order testing, prescribe medications and collaborate with Millennium Medical Management physicians on all patients in the practice (clinic and the hospital), and generally serve as 'physician extenders'. **WE ABSOLUTELY DO NOT PRESCRIBE NARCOTIC/OPIOD PAIN MEDICATIONS AT THE FIRST VISIT.**

Some patients may or may not see the physician at the time of their visit, depending on their needs and whether all necessary diagnostic tests and imaging are available for the physician to review. However, it is our intention each and every patient at each of their visits is seen by the physician, and a physician reviews the work of all staff during clinic. In compliance with state laws, all patients have the right to see the providing physician, and in the event that he is physically unavailable, and the patient does not want to see the PA/NP, we will be happy to reschedule to the next available appointment.

Our physicians establish the plan of care for each patient individually. The doctors and our mid-level providers have close professional and personal relationships and frequently discuss patient needs and issues whether they are in the office, hospital, home, etc. We have developed our office protocols after years of research, experience, and the latest published standards of care for our specialty. Our physicians' visits with you will be focused, in depth, and to the point. In providing the highest quality of care to the patients in our very busy clinic, this approach works very well.

If you are scheduling surgery or a procedure, you will meet the **Surgery Coordinator** or **Procedure Coordinator**. The Coordinator will guide you through all of the steps prior to your surgery date. They will review pre- and post-operative instructions fit you for any necessary braces or collars, schedule your pre-surgical clearance appointment with your Primary Care Physician, Internist, or Cardiologist, and be a resource person for your pre- and post-surgical questions.

The **Clinical Director** is responsible for the day-to-day hands on running of the clinic here in Viera. If you should have any questions or comments about process, please contact her as she works closely with the physicians and the rest of the team to ensure that your experience here is a positive one.

Expect **your initial appointment** to take up to 2 hours. If the surgeon has a complicated medical situation with another patient or an emergency, there may be a wait beyond your appointment time that may be as long as an hour. We work hard to keep wait times to a minimum and will advise you in advance when a wait can be expected.

Some of our new patients come to us because they attended one of our **educational symposiums** or seminars, or they may have been referred by another physician. **All new patients must complete the new patient packet of forms and bring it to their appointment.** Patient forms are available on our website at www.DeukSpine.com under *Resources*.

Our mission at Millennium Medical Management is to fix back, neck and joint pain through a continuum of care philosophy in state-of-the-art facilities with world class surgeons and physicians. We want you to have exceptional service and the best medical care available anywhere, and *we pledge to put the Patient first.*



Patient Name: _____ Date of Birth: _____

836 Century Medical Drive
Titusville, FL 32796-2141
Phone 321-383-8092
Fax 321-383-1043

7955 Spyglass Hill Road #A
Melbourne, FL 32940-8249
Phone 321-255-6670
Fax 321-242-2545

Patient Name: _____

So that we may keep your family physician and/or referring physician informed of your progress under our care, please list the name and address of that physician:

Primary Care Physician: _____

Address: _____

Phone: _____ Fax: _____

Referring Physician: _____

Address: _____

Phone: _____ Fax: _____

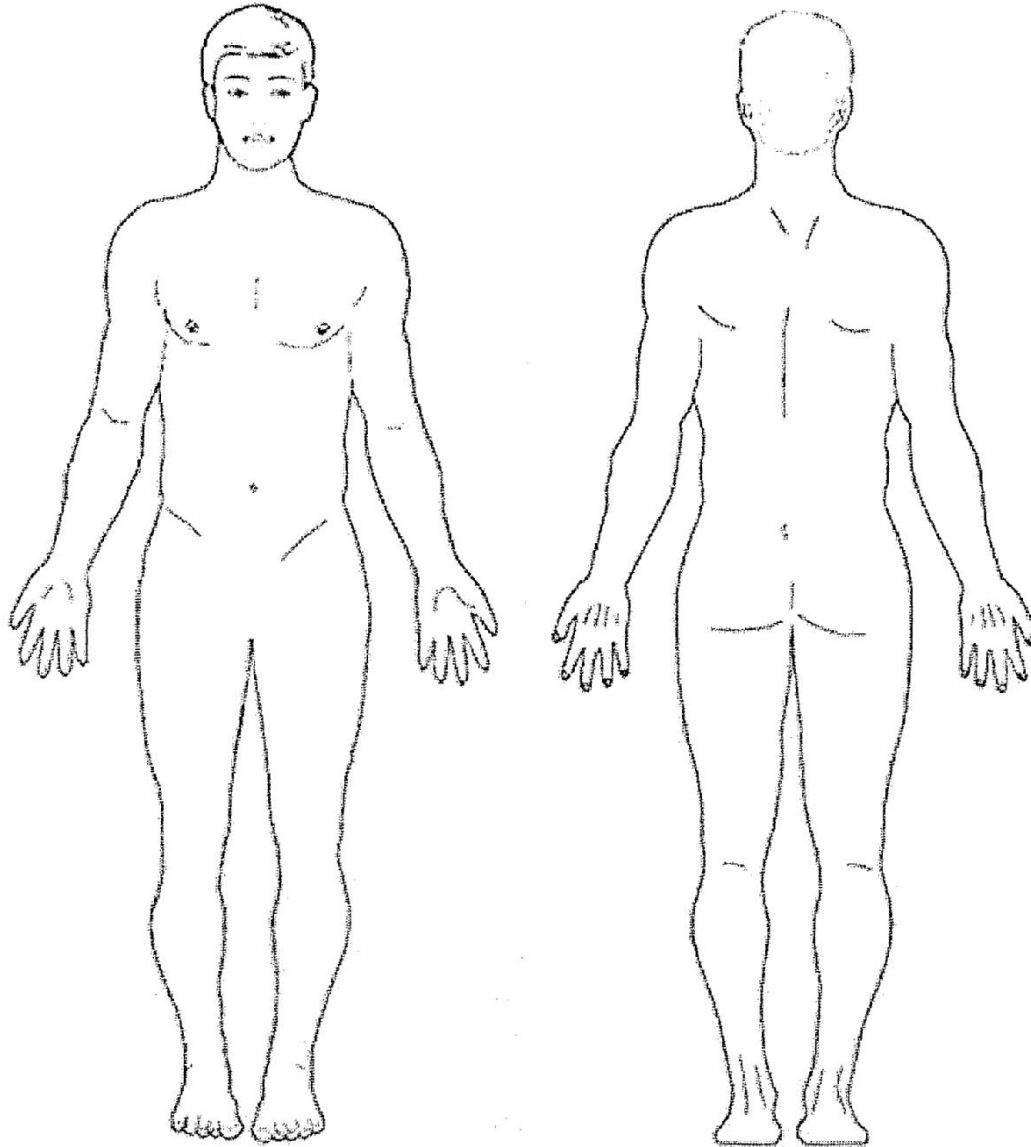
Patient Signature

Date

History and Physical Pain Map

Using the symbols below, please draw in the location of your symptoms on the diagrams.

- X= Pain
- O= Numbness
- /= Weakness
- *= Pins & Needles

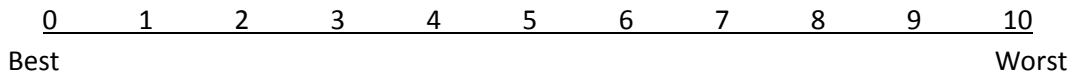


If you have NECK PAIN, what percentage is Neck _____% and _____% Arm, (Total 100%)

If you have BACK PAIN, what percentage is Back _____% and _____% Leg. (Total 100%)

Mark an X on the line indicating your usual amount of pain.

(0 Meaning No Pain, 10 Meaning Worst Pain)



HEALTH HISTORY

Please complete this Questionnaire.

DATE: _____

It is designed to give us information about your Health, that will allow us to better understand and assist you.

Patient Name: _____ Date of Birth: _____ Age: _____

Sex: Male Female Weight: _____ Height: _____ Race: _____ Ethnicity: _____

What is the main reason for you visit today? _____

Other Concerns: _____

What are your health goals for the next year? _____

In the past 2 weeks, have you been bothered by: Little interest or pleasure in doing things? No Yes
Feeling down, depressed or hopeless? No

Yes

REVIEW OF SYSTEMS: Please mark the box and /or circle any **persistent** symptoms you have had in the **past few months**. Read through every section and check “no problems” if none of the symptoms apply to you. List other concerns above.

General

- ___ Unexplained weight loss/ gain
- ___ Unexplained fatigue/ weakness
- ___ Fall asleep during day when sitting
- ___ Fever, Chills
- ___ **No Problems**

Skin

- ___ New or change in mole
- ___ Rash /itching
- ___ **No Problems**

Breast

- ___ Breast lump/pain/nipple discharge
- ___ **No Problems**

Ears/Nose/Throat

- ___ Nosebleeds, trouble swallowing
- ___ Frequent sore throat, hoarseness
- ___ Hearing loss / ringing in ears
- ___ **No Problems**

Eyes

- ___ Change in vision/ eye pain/ redness
- ___ **No Problems**

Cardiovascular

- ___ Chest Pain / discomfort
- ___ Palpitations (fast or irregular Heartbeat)
- ___ **No Problems**

Respiratory

- ___ Cough /wheeze
- ___ Loud Snoring / altered breathing during sleep
- ___ Short of breath with exertion
- ___ **No Problems**

Gastrointestinal

- ___ Heartburn / reflux/ indigestion
- ___ Blood or change in bowel movement
- ___ Constipation
- ___ **No Problems**

Genitourinary

- ___ Leaking urine
- ___ Blood in urine
- ___ Nighttime urination or increased frequency
- ___ Discharge: penis or vagina
- ___ Concern with sexual functions
- ___ **No Problems**

Musculoskeletal

- ___ Neck Pain
- ___ Back Pain
- ___ Muscle /Joint Pain _____
- ___ **No Problems**

Endocrine

- ___ Heat or cold sensitivity
- ___ **No Problems**

Hematologic/ Lymphatic

- ___ Swollen glands

- ___ Easy Bruising

- ___ **No Problems**

Neurological

- ___ Headache
- ___ Memory loss
- ___ Fainting
- ___ Dizziness
- ___ Numbness/tingling
- ___ Unsteady gait
- ___ Frequent infections
- ___ **No Problems**

Allergic/Immune

- ___ Hay fever/ allergies
- ___ Frequent infections
- ___ **No Problems**

Psychiatric

- ___ Anxiety / stress /irritability
- ___ Sleep problem
- ___ Lack of concentration
- ___ **No Problems**

Women Only

- ___ Pre-menstrual symptoms (bloating cramps, irritability)
- ___ Problem with menstrual periods
- ___ Hot flashes / night sweats
- ___ **No Problems**

Immunizations: Check off any vaccinations you have had in the past. Add year if known.

 Tetanus (Td) ___ With Pertussis (Tdap) ___ Varicella (Chicken Pox) shot or illness ___ Pneumovax (pneumonia) ___
 Influenza (flu shot) ___ Hepatitis A ___ Hepatitis B ___ MMR ___ Meningitis ___ Zostavax (shingles) ___ HPV ___

List ALL CURRENT MEDICATIONS as follows:

Name	Dose milligram, grams)	How many time a day	How long

DRUG ALLERGIES

Drug	Type of Reaction

Are you allergic to Latex? Yes No

Do you take Blood Thinners (Coumadin, Plavix, Aggrenox, Ticlid, Pletal) Yes No

HEALTH MAINTENANCE SCREENING TESTS:
Lipid (cholesterol) Date: _____ **Abnormal** Yes No

Sigmoidoscopy or Colonoscopy Date: _____ **Abnormal** Yes No

Women Only:
Mammogram Date: _____ **Abnormal** Yes No

Pap Smear Date: _____ **Abnormal** Yes No

Bone Density Test Date: _____ **Abnormal** Yes No

SOCIAL HISTORY & HABITS

Occupation _____ Marital Status _____ Highest Education _____

WORK STATUS:

Full duty Light duty Off duty per Physician Unemployed Retired

 If you are **NOT** working full duty:

How long have you been off work? _____

Have you had a work capacity assessment? Yes No

Are you disable through Social Security? Yes No

TOBACCO USE

Do you currently use Tobacco products? Yes No Started Age/Year _____ Stopped _____

If yes, indicate the quantity per day:



Patient Name: _____ Date of Birth: _____

Cigarettes _____ Cigars _____ Chewing Tobacco (snuff) _____

05 Health History

Tab-Health History/ICS-History and Physical

ALCOHOL USE

Do you currently consume alcoholic beverages? Yes No

If yes, indicate the quantity per day and answer four questions (to right):

Beer:___ Wine:___ Distilled Spiritis:___

Have you ever been treated for drug or alcohol addiction? Yes No

- | | | |
|--|-----|----|
| 1. Have you ever felt you needed to cut down on your drinking? | Yes | No |
| 2. Have people annoyed you by criticizing your drinking? | Yes | No |
| 3. Have you ever felt guilty about drinking? | Yes | No |
| 4. Have you ever felt you needed a drink first thing in the morning to steady your nerve or get rid of a hangover? | Yes | No |

SEXUAL ACTIVITY:

Sexually involved currently: Yes No

Sexual Partner(s) is/are/have been Male Female (circle one)

Birth control method (circle below all that apply): None Needed Condom Pill Diaphragm Vasectomy, Other: _____

PERSONAL MEDICAL HISTORY: So you have now (current) or have you had (past) any of the following conditions?

none

Condition:	Code:	Current	Past	Personal Med History Cont.	Code:	Current	Past
Alcohol/ Drug Abuse	305.00/305.90			Gout	274.9		
Allergy (Hay Fever)	477.9			Gynecological Cond. (Endometriosis)	617.9		
Anemia	285.9			Gynecological Cond. (Fibroids)	218.9		
Anxiety	300.00			Gynecological Cond. (other)			
Arthritis (Rheumatoid)	714.0			Heart Attack	410.90		
Arthritis (Osteoarthritis)	715.90			Hepatitis A	070.1		
Asthma	493.90			Hepatitis B	070.30		
Bladder /Kidney Problems				Hepatitis C	070.51		
Blood Clot (Leg)	453.40			Hepatitis Other	070.59		
Blood Clot (Lung)	415.11			High Blood Pressure	401.9		
Blood Transfusion	V58.2			High Cholesterol	272.0		
Breast Lump (benign)	611.72			Hip Fracture	820.8		
Cancer Breast	174.9			Irritable Bowel Syndrome	564.1		
Cancer Colon	153.9			Kidney Disease/ Failure	586		
Cancer Other Type				Kidney Stones	592.0		
Cancer Ovarian	183.0			Liver Disease	573.9		
Cancer Prostate	185			Migraine Headaches	346.90		
Cataracts	366.9			Osteoporosis	733.00		
Chicken Pox	052.9			Pneumonia	486		
Colon Polyp	211.3			Prostate (enlargement)	600.00		
Coronary Artery Disease	414.00			Prostate (nodules)	600.10		
Depression	311			Seizure / Epilepsy	780.39		
Diabetes (adult onset)	250.00			Skin Condition (Eczema)	692.9		
Diabetes (childhood onset)	250.01			Skin Condition (Psoriasis)	696.1		
Diverticulitis	562.10			Skin Condition (Abn. Moles)	238.2		
Emphysema	492.8			Sleep Apnea	780.57		
Fractures (broken bones)				Stomach Ulcer	531.90		
Gallbladder Disease	574.20			Stroke	434.91		
GERD	530.81			Thyroid (Nodule)	241.0		
Glaucoma	365.9			Thyroid High (Overactive)/ Hyperthyroidism	242.90		
				Thyroid Low (Underactive) / Hypothyroidism	244.9		
				Other (List)			
				Other (List)			



Patient Name: _____ Date of Birth: _____
 05 Health History Tab-Health History/ICS-History and Physical

SURGICAL HISTORY: Please check off any procedure or surgeries. List any abnormal finding or complications. None

Surgical Procedure	Year	Comments:
Abdominal Surgery		
Appendectomy (appendix removal)		
Back Surgery (lumbar)		
Biopsy (location)		
Breast Biopsy		Circle: Right Left Both
Breast Surgery		Circle: Right Left Both
Colonoscopy		
Coronary Bypass		
Coronary Stent's		
EGD (Stomach Endoscopy)		
Cataract		Circle: Laparoscopic
Gallbladder Removal		
Heart Surgery (other than coronary bypass)		
Hip Surgery		Circle: Right Left Both
Hysterectomy (total, including ovaries)		Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (partial, ovaries left)		Circle: Laparoscopic Vaginal Abdominal
Knee Surgery		Right: Left: Bilateral
LEEP (Cervix Surgery)		
Neck Surgery (cervical)		
Ovary Ligation (tubal)		
Ovary Removal		Right: Left: Bilateral
Vasectomy		
Sigmoidscopy		
Sinus Surgery		
Other (list)		

Adopted – Yes No (Please Circle) If yes and you do not know your family history skip this section and continue to other health issues.

FAMILY HISTORY- Indicate which relative has had the following diseases (parents and siblings are most important).

Disease	Mother	Father	Sister(s)	Bother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
No Significant history known										
Alcoholism / Drug abuse										
Alzheimer's										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer Breast										
Cancer Colon										
Cancer Other Type										
Cancer Ovarian										
Cancer Prostate										
Colon Polyp										
Coronary Artery Disease										
Depression, Suicide, Anxiety										
Diabetes (childhood)										
Diabetes (Adult Onset)										
Emphysema (COPD)										
Genetic Disorder (Explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
High Blood Pressure hypertension										
High Cholesterol										
Hip Fracture										
Hypothyroidism/ Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis										



Patient Name:

Date of Birth:

Other (list)

05 Health History

Tab-Health History/ICS-History and Physical

The preceding patient information packet has been reviewed and discussed with the patient.

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____



Patient Name: _____ Date of Birth: _____

Assignment of Insurance Benefits; Privacy; Payments; Appointments

Assignment of Insurance Benefits

I authorize payment to Millennium Medical Management, LLC for all insurance benefits otherwise payable to me for any services rendered. I authorize Millennium Medical Management, LLC to release to my insurance carrier any medical records or other information needed to determine benefits payable for any services provided. I understand that I am financially responsible to Millennium Medical Management, LLC for charges/benefits not covered by this assignment. I also understand that Millennium Medical Management, LLC is not responsible for the terms of the contracts which I have with my insurance companies.

Notice of Privacy Practices

I have reviewed the posted copy of Florida Department of Health’s Notice of Privacy Practices. This Notice describes how my medical information may be used and disclosed and how I can obtain access to this information (a copy for your records is available upon request).

Consent to Release

I give authorization for Millennium Medical Management to discuss my **medical/health care** with the following family members or close friends:

Full Name: _____ Relation: _____
_____ _____
_____ _____

I give authorization for Millennium Medical Management to discuss my **account finances** with the following family members or close friends:

Full name: _____ Relation: _____
_____ _____
_____ _____

Payment Policy

Millennium Medical Management accepts most forms of payment including checks, debit cards, credit cards and credit facilities like CareCredit and MedFin. Millennium Medical Management reserves the right to charge 1.5% interest per month, compounded daily, after 90 days of non-payment on all outstanding balances. Credit cards and other revolving credit programs have chargeback provisions to allow, for example, return of purchased goods that are the wrong size or color. Those chargeback features are not appropriate at *Millennium Medical Management* so we are asking that you waive your rights for chargebacks. If a chargeback occurs, Millennium Medical Management may initiate legal action to recoup the charges and you will be held responsible for all resulting legal fees and other appropriate expenses to recoup those charges. I also understand that *Millennium Medical Management* will assess a \$50 fee on all checks that are returned as unpaid.

Cancellation and No Show Policy

At Millennium Medical Management our goal is to provide quality medical care to you and the rest of our patients. In an attempt to be fair to all patients seeking our care, we have implemented a Cancellation and No Show Policy. If you must cancel an appointment for an office visit, we ask that you please call at least 24 hours prior to the appointment, or earlier if possible. Canceled office visits less than 24 hours before the appointment mean we cannot usually fill the appointment with another patient. If you fail to call and are a “no show”, your appointment slot cannot be filled and means more costs for our practice, so please call us if you need to cancel an appointment.

To cancel an appointment, call Patient Services at 321-751-3389 or 1-800-724-6349 (1-800-Pain-Fix). Each cancellation and /or “no show” is tracked in our system and you will receive a cancellation number. Repeated cancellations or ‘no shows’ may require us to discharge you from the practice. Thank you!

In the event that surgery is recommended, I _____ acknowledge that I am _____ non-smoker _____ smoker. Smoking is associated with an increased risk of pseudo-arthritis and other surgical complications. I will refrain from tobacco use for at least six (6) weeks prior to the planned surgery.

Patient Name _____

Patient Signature _____ Date _____

Mutual Agreements, Consents and Resolution of Concerns

1. Privacy and Ratings

Millennium Medical Management agrees not to provide medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Millennium Medical Management will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Millennium Medical Management has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about Millennium Medical Management - our practice, expertise, and/or treatment - on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Millennium Medical Management, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Millennium Medical Management for any written, pictorial, and/or electronic commentary. This assignment shall be effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be for a period of five years from Millennium Medical Management's last date of service to Patient. Millennium Medical Management requires all patients in its practice to sign the Mutual Agreement to establish that any anonymous publishing or airing of commentary will be covered by this agreement. Further, this Agreement will survive for a minimum of three years beyond any termination of the Millennium Medical Management - Patient relationship.

Patient and Millennium Medical Management acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Millennium Medical Management agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this provision result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

2. Surgical Consent Modification

We recognize that you have a choice in receiving care. We take great pride in our reputation for providing the highest levels of quality medical care to our patients. However, we realize there are times when some patients might not be satisfied with the outcomes of their treatments.

Every patient has a right to file a complaint with the Division of Medical Quality Assurance, Board of Medicine. But, that right is not unlimited. For example, those who file complaints in bad faith can be subject to civil liability (Florida Statutes § 456.073 (11)). In the context of balancing your rights with those of the physician, I, the patient, agree to the following:

1. If a complaint related to my care is ever filed (by my agent or me) with the Division of Medical Quality Assurance, I will only do so in good faith, addressing matters only related to my health and welfare.
2. In particular, I understand that there are risks inherent to any surgical procedure and these risks have been explained to me prior to the procedure. I have signed that consent voluntarily and with my free will. And I have had an opportunity to ask questions and have them answered to my satisfaction. In that context, a complaint to the Division of Medical Quality Assurance, founded on any such realized risks, unless there is clear and convincing evidence to the contrary, will be construed as bad faith.
3. Next, should a complaint be filed with the Division of Medical Quality Assurance related to standard of care, I, the patient, will explicitly request that the complaint be reviewed by a member of my specialty; that specialty being Neurosurgery, Spinal Surgery, Orthopedic Surgery, Pain Management or Neurology.
4. Finally, should the complaint allege facts that can be disrupted by the clear medical record, I, the patient, will voluntarily withdraw my complaint if that portion of the medical record is drawn to my attention. I will have the right to inspect and review the medical record to correct any perceived error in the medical history. Such corrections must be performed within two weeks of the treatment received

3. Resolution of Concerns

I understand that I am entering into a contractual relationship with Physician(s) of Millennium Medical Management for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative, agree not to initiate or advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use American Board of Medical Specialties ("ABMS") board-certified expert medical witness (es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and/or code of conduct defined for expert witnesses by the



Patient Name: _____ Date of Birth: _____

American Board of Neurosurgery, American Board of Interventional Pain Management, American Academy of Pain Management, American Board of Electrodiagnostic Medicine, American Board of Physical Medicine and Rehabilitation, American Board of Orthopedic Surgery and American Board of Psychiatry and Neurology and American Board of Family Practice.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician’s reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

4. Waiver

Article 1, Section 21 of the Florida Constitution reads as follows: Access to court – The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay. The Undersigned patient understands and acknowledges that: I have been advised that signing this waiver releases an important constitutional right; and I have been advised the I may consult with counsel before signing this waiver; and by signing this waiver I agree that if any controversy arises out of or in any way relating to the current, future or past diagnosis, treatment, or care that I have or will receive from Millennium Medical Management, LLC, it’s physicians, agents or employees, the maximum amount of any non-economic damages that can be awarded in any such action will be \$250,000. This limit applies regardless of the number of claimants or defendants in the proceeding. There is no limit on the amount of economic damages that a jury may award; and I have three (3) business days following execution of this waiver in which to cancel this waiver; and I wish to engage the medical services of Millennium Medical Management, but I am unable to do so because of the provisions of the constitutional limitation set forth above. In consideration of the physician or group of physicians’ agreements to provide medical services to me and my desire to receive medical services from the physician or group of physicians listed below, I hereby knowingly, willingly, and voluntarily waive the right, in an action in a court of law for any controversy, including any malpractice claim, arising out of or in any way relating to the diagnosis, treatment, or care of the patient by Millennium Medical Management, including any partners, agents, or employees of the physician, to recover non-economic damages in excess of \$250,000; and I have selected Millennium Medical Management as my physician group of choice in this matter and would not be able to retain their medical services without this waiver; and I expressly state that this waiver is made freely and voluntarily, with full knowledge of its terms, and that all questions have been answered to my satisfaction. I understand that this waiver will remain in effect for one year from the date that I have signed this form.

ACKNOWLEDGEMENT BY PATIENT FOR PRESENTATION TO THE COURT

The undersigned patient hereby acknowledges, under oath, the following:

I have read and understand this entire waiver of my right under the constitutional provision set forth above. I am not under the influence of any substance, drug, or condition (physical, mental, or emotional) that interferes with my understanding of this entire waiver in which I am entering and all the consequences thereof. I have entered into and signed this waiver freely and voluntarily.

I authorize Millennium Medical Management to present this waiver to the appropriate court, if required. Unless the court requires my attendance at a hearing for that purpose, Millennium Medical Management is authorized to provide this waiver to the court for its consideration without my presence.

DATED this _____ day of _____, 20____ By: _____
PATIENT

Sworn to and subscribed before me this _____ day of _____, 20____ by _____, who is personally known

to me, or has produced the following identification: _____.

Notary Public Signature

My Commission Expires:

Financial Guidelines

Form of Pay	You are responsible for...	We will...
Medicare	<p>If you have standard Medicare, and have not met your \$140 deductible, we ask that it be paid at the time of service. For any services not covered by Medicare, payment is also requested at the time of the visit.</p> <p>If you have regular Medicare as your primary insurance and also have a secondary insurance or Medigap coverage: No payment is required at the time of the visit after your Medicare deductible has been met. If your secondary insurance does not send payment within 45 days, a bill for the balance will be sent to you.</p> <p>If you have regular Medicare as your primary insurance and no secondary insurance: Be prepared to pay your 20% co-insurance at the time of the visit.</p>	Accept your Medicare deductible payment (if applicable), any co-insurance amount, file the claim on your behalf including any claims to your secondary insurance.
Medicare HMO Fee-For-Service In-Network HMO/PPO Plans	<p>All applicable co-payments and deductibles at the time of the visit.</p> <p>If the services you received are covered by your plan: All applicable co-payments and deductibles apply and are due at the time of the visit. If authorization is required by your insurance, you must verify with provider's office before your visit.</p>	Accept your payment and file a claim to your insurance.
Limited Plans	Full payment for services provided at the time of service.	Accept your payment and file a claim to your insurance without accepting assignment.
Commercial Insurance Out of Network	All applicable co-payments and deductibles at the time of the visit.	Accept your payment and file a claim to your insurance.
Self Pay	<p>Payment in full at the time of service for office visit, injections, and for any other service provided. You may be asked to make a deposit at the time of registration.</p> <p>Payment in FULL at time of service is expected. For patients scheduled to see our specialists, the deposit amount is \$250-\$500 (New Patients) and \$150-\$300 (Established Patients) and any additional fees will be settled at time of visit.</p> <p>Credit, debit, check are accepted methods of payment. If you are a NEW patient please come prepared to pay by credit or debit.</p>	Accept your payment.
HSA Plans	You must return to the Registration area to pay with your HSA Debit Card.	Accept your HSA Card payment.
Workers Comp or MVA	If an authorization to treat has been obtained from your carrier, no payment will be required at time of visit. If an Authorization is not in place, your appointment will be re-scheduled.	Schedule your appointment after services have been authorized by your carrier.

General Information:

Our Staff will schedule an appointment for you once your coverage has been verified.

You are responsible for providing the correct information regarding your insurance coverage at the time of your visit. You are also responsible for knowing what your benefits are. If you don't understand what your benefits are, please contact your insurance carrier by calling the customer service number on your insurance card.

Request for form completion including FMLA, Jury Duty Exemption, and other forms will have a charge at the physician/clinic's discretion starting at \$25 per form, varying based on form complexity and length. Our staff will return forms to patient/requestor in a timely manner.

Cancellations & No Shows

Millennium Medical Management staff will contact you prior to your scheduled appointment . If you cannot make your appointment, please cancel at least 24 hours in advance. Your appointment slot could go to another patient