Welcome to Millennium Medical Management, the home of…
Primary Care of Brevard, Deuk Spine Institute, Injury Treatment Group and Viera Orthopedics
Enclosed, you will find a map to our offices. We look forward to seeing you!

Please remember…

✓ Bring your 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.

Appointment Date _____ Time _____

☐ Viera ☐ Titusville

Please arrive 30 minutes prior to your scheduled appointment time.

Viera/Melbourne Office:
7955 Spyglass Hill Road Suite A, Melbourne, FL 32940
Phone: (321) 255-6670 Fax: (321) 242-2545

Things to Know About Our Office

We collect insurance deductibles, co-pays, and coinsurances upon checking in.
Viera Check or Credit Card Only. **No cash**, please.

Please allow 48-72 hours for all prescription refill requests. Some prescriptions cannot be called into the pharmacy, but can be picked up at our office.

Appointment reminders are sent through email, phone calls, and optionally text messages.
To receive text reminders, please text the word NOTIFY to 37509

Viera office hours are Monday through Friday, 8:00am to 5:00pm.

Directions To Viera Office

Start out on I-95.

Take Exit 191 for Wickham Rd toward Viera/Brevard County 509 — 0.30 miles

Merge onto N Wickham Rd/FL-404/County Hwy-509 heading Eastbound — 0.60 miles

Follow signs for Wickham Road E

Turn left onto Murrell Rd. — 0.50 miles

- *Murrell Rd is 0.1 miles past Sheriff Dr*

If you are on N Wickham Rd and reach Office Park Pl you've gone about 0.1 miles too far

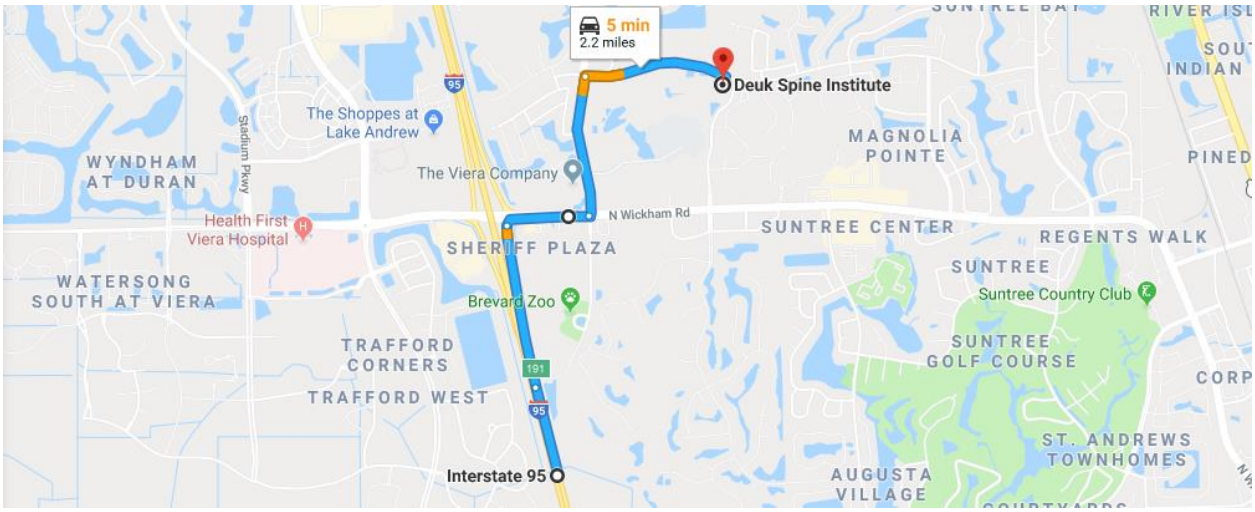
Turn right onto Spyglass Hill Rd. — 0.50 miles

- *Spyglass Hill Rd is 0.2 miles past Hammock Trace Dr*

If you reach Crane Creek Blvd you've gone about 0.3 miles too far

7955 Spyglass Hill Rd, FL, 32940-8135, 7955 SPYGLASS HILL RD is on the right. — 0.00 miles

- *Your destination is just past Classic Ct*
- *If you reach Baytree Dr you've gone a little too far*



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 are 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*.

Pharmacy Information Request Form

Patient Name & Address: _____

_____

_____

Patient Phone Number: _____

Pharmacy Name & Address: _____

_____

_____

Pharmacy Phone Number: _____

_____ _____

Patient Signature Date

_____ _____

Verified By Date

Patient Name: _____ DOB: _____

So that we may keep your primary care 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**

Medical Records Release

Patient Name: _____

SSN# XXX-XX- _____ Date of Birth: _____

I hereby authorize _____ to release the following information on my behalf:

____ Demographic/Insurance Information
____ Entire Medical Record: From: _____ To: _____
____ Partial Medical Record: From: _____ To: _____
___ Dictated Notes/Reports
___ Radiology Reports
___ Lab Work
Other: _____

Please send the selected information to:

Lori Shellenback, ARNP

Primary Care of Brevard
7955 Spyglass Hill Road Suite A
321-255-6670 phone
321-255-1996 fax

_____ _____
Patient/Legal Representative Signature Date

_____ _____
Witness Signature Date

_____
(Validation of legal representative must be in patient chart)

I understand these records may contain information from other health care providers, as well as information which are administrative in nature. This information will be given only to those specified on this form and only through the expiration date stated below. I also understand I have the right to revoke this authorization at any time through written notice and that written notice must include: 1) The patient's name, social security number, and DOB, 2) reference to this specific authorization and the name of those authorized by this form to receive this information, 3) a statement that the patient wants to revoke this authorization, the effective date of revocation, and the signature of the patient or legal guardian.

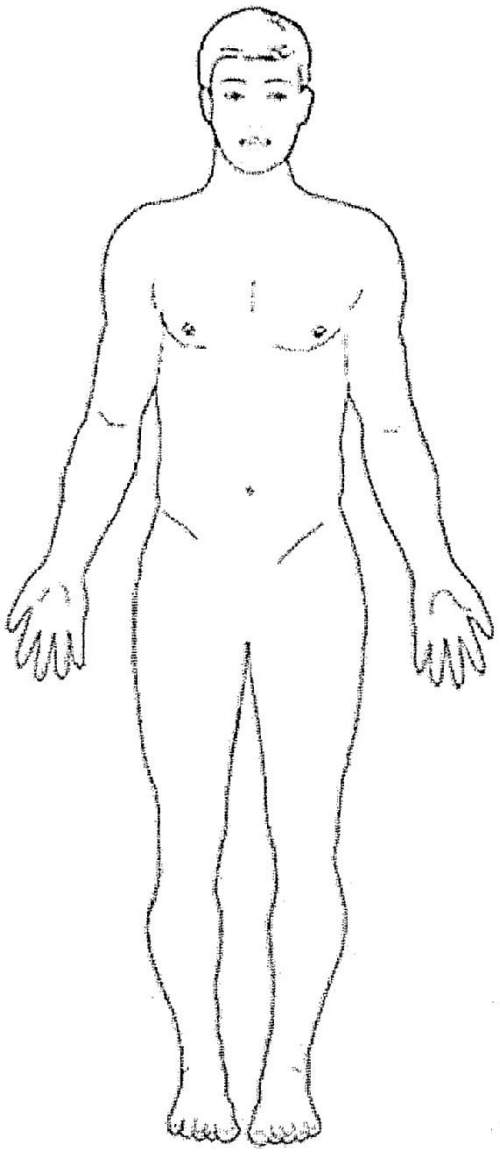
I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal laws or regulations. This authorization will expire six months from the date specified above.

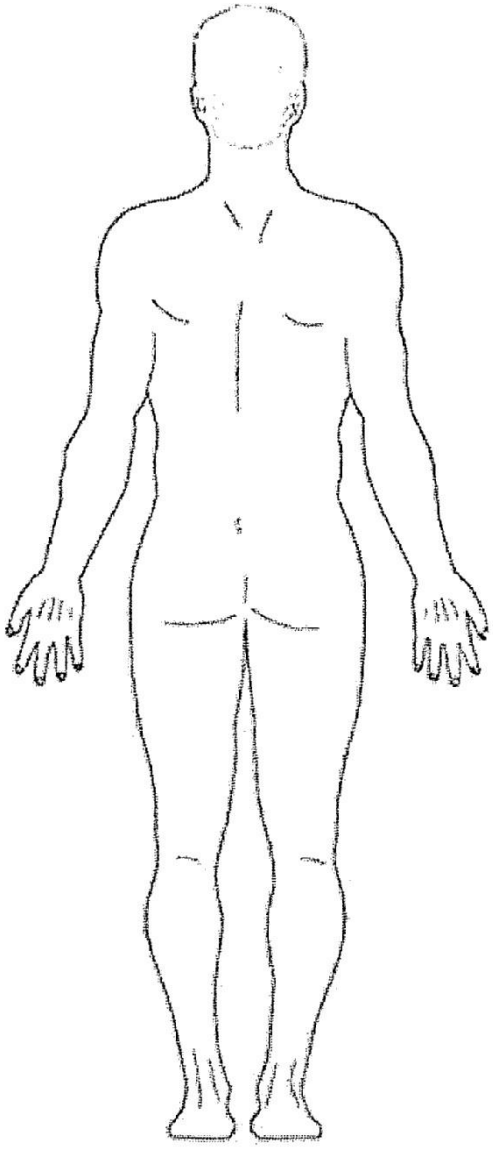
PRIMARY CARE
OF BREVARD

History and Physical Pain Map

Using the following symbols, 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)

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain

PRIMARY CARE OF BREVARD

Health History

Please complete this Questionnaire.
It is designed to give us information about your
health, which will allow us to better understand and assist you.

Patient Name: _____ **DOB:**_____ **Sex:** ___ M ___ F

Weight: _____lbs **Height:** ____ft ____in **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*

Gastrointestinal
___ Heartburn / reflux/ indigestion
___ Blood or change in bowels
___ Constipation
___ *No Problems*

Allergic/Immune
___ Hay fever/ allergies
___ Frequent infections
___ No Problems

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

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

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

Genitourinary
___ Leaking urine
___Blood in urine
___ Nighttime urination or increased frequency
___ Discharge: penis or vagina
___Concern with sexual functions
___ *No Problems*

Women Only
___ PMS Symptoms (bloating, cramps, irritable)
___ Problem with menstrual periods
___ Hot flashes / night sweats
___ *No Problems*

Hematologic/ Lymphatic
___ Swollen glands
___ Easy Bruising
___ *No Problems*

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

Endocrine
___ Heat or cold sensitivity
___ *No Problems*

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

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

Cardiovascular
___ Chest Pain / discomfort
___ Palpitations
___ *No Problems*

Musculoskeletal
___ Neck Pain
___ Back Pain
___ Muscle /Joint Pain
___ *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:

Medication Name	Dose (milligrams, grams)	How many times per 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 & Status

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 of work? _____
Have you had a work capacity assessment? □ **Yes** □ **No** Are you disabled through Social Security? □ **Yes** □ **No**

PRIMARY CARE OF BREVARD

Alcohol Use

Do you currently consume alcoholic beverages? □ **Yes** □ **No**
Quantity per day? Beer: ____ Wine: ____ Spirits: ____

Please answer the sidebar questions: → → →
Have you ever been treated for a drug or alcohol addition? □ **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 nerves, or to get rid of a hangover? □ **Yes** □ **No**

Sexual Activity

Currently sexually active? □ **Yes** □ **No**
Sexual partner(s) is/are/have been: □ **Male** □ **Female**
Birth control method? □ **None** □ **Condom** □ **Pill** □ **Diaphragm** □ **Vasectomy** □ **Other: _____**

Personal Medical History

Do you currently have, or have you ever had, any of the following conditions?

Condition:	**Code:**	**Current**	**Past**	**Comments**
Alcohol/ Drug Abuse	305.00/305.90			
Allergy (Hay Fever)	477.9			
Anemia	285.9			
Anxiety	300.00			
Arthritis (Rheumatoid)	714.0			
Arthritis (Osteoarthritis)	715.90			
Asthma	493.90			
Bladder /Kidney Problems				
Blood Clot (Leg)	453.40			
Blood Clot (Lung)	415.11			
Blood Transfusion	V58.2			
Breast Lump (benign)	611.72			
Cancer Breast	174.9			
Cancer Colon	153.9			
Cancer Other Type				
Cancer Ovarian	183.0			
Cancer Prostate	185			
Cataracts	366.9			
Chicken Pox	052.9			
Colon Polyp	211.3			
Coronary Artery Disease	414.00			
Depression	311			
Diabetes (adult onset)	250.00			
Diabetes (childhood onset)	250.01			
Diverticulitis	562.10			
Emphysema	492.8			
Fractures (broken bones)				**Where?**
Gallbladder Disease	574.20			
GERD	530.81			
Glaucoma	365.9			

Personal Med History Cont.	Code	Current	Past	Comments:
Gout	274.9			
Gynecological Cond. (Endometriosis)	617.9			
Gynecological Cond. (Fibroids)	218.9			
Gynecological Cond. (other)				
Heart Attack	410.90			
Hepatitis A	070.1			
Hepatitis B	070.30			
Hepatitis C	070.51			
Hepatitis Other	070.59			
High Blood Pressure	401.9			
High Cholesterol	272.0			
Hip Fracture	820.8			
Irritable Bowel Syndrome	564.1			
Kidney Disease/ Failure	586			
Kidney Stones	592.0			
Liver Disease	573.9			
Migraine Headaches	346.90			
Osteoporosis	733.00			
Pneumonia	486			
Prostate (enlargement)	600.00			
Prostate (nodules)	600.10			
Seizure / Epilepsy	780.39			
Skin Condition (Eczema)	692.9			
Skin Condition (Psoriasis)	696.1			
Skin Condition (Abn. Moles)	238.2			
Sleep Apnea	780.57			
Stomach Ulcer	531.90			
Stroke	434.91			
Thyroid (Nodule)	241.0			
Thyroid High (Overactive)/ Hyperthyroidism	242.90			
Thyroid Low (Underactive) / Hypothyroidism	244.9			
Other (List)				
Other (List)				

PRIMARY CARE OF BREVARD

SURGICAL HISTORY

Please check off any procedures or surgeries in your history. List any abnormal finding or complications.

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

Adopted? □ Yes □ No

If yes and you do *not* know your family history, please skip the following section.

Family History

Please indicate which (if any) relatives have had the following diseases. Parents & 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										

Disease Cont.	Mother	Father	Sister(s)	Bother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
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										
Other (list)										

PRIMARY CARE
OF BREVARD

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_____

Hereditary Cancer Questionnaire

Personal Information

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

Gender (M/F): _____ **Today's Date(MM/DD/YY):** _____ **Healthcare Provider:** _____

Reason for Today's Visit: _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	-------	---	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLORECTAL POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Personal and/or family history of any one of the following:

☐	**Multiple** A combination of cancers on the same side of the family:	o **2 or more**: breast / ovarian / prostate / pancreatic cancer o **2 or more**: colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) o **2 or more**: melanoma / pancreatic
☐	**Young** Any 1 of the following at age **50 or younger**:	o Breast cancer o Colorectal cancer o Endometrial cancer o Ovarian cancer
☐	**Rare** Any 1 of these rare presentations at **any age**:	o Breast: Male breast cancer or Triple negative breast o 10 or more colorectal polyps* o Colorectal cancer with abnormal MSI/IHC, or MSI associated histology †† o Endometrial cancer with abnormal MSI/IHC o 10 or more colorectal polyps*

††Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern *Adenomatous type

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment:

PRIMARY CARE OF BREVARD

Name: _____ **Date:** _____

Date of Birth: _____

Health Consult

1. Do you have high blood pressure? □ Yes □ No
2. Has it been over one year since you last completed blood tests? □ Yes □ No
3. Has it been over one year since your last visit to an eye doctor? □ Yes □ No
4. When was your last colonoscopy? _____ Was it normal? □ Yes □ No
5. Is there any family history of cancer? If yes, type, age and relation? _____
6. Colon Cancer? □ Yes □ No If yes, age and relation? _____
7. What is your current exercise plan? _____
8. Alcohol use? How much, since what age? _____

Immunizations

1. Did you have a Flu shot this season? _____
2. Have you ever had a Pneumonia shot? When? _____
   (The Pneumonia shot is important for those ≥ 65 years old, smokers, those with asthma/COPD, diabetes, etc)

Men

1. Family history of Prostate (or other male specific) cancer? □ Yes □ No
   If yes, age and relation? _____

Women

1. Date of last pap smear _____ Was it normal? □ Yes □ No
2. Date of last mammogram _____ Was it normal? □ Yes □ No
3. Family history of breast, cervical, ovarian, or uterine cancer? □ Yes □ No
   If yes, age and relation? _____

Please provide a copy of the most recent above stated reports along with your immunization record.

Assignment of Insurance Benefits; Appointment of Authorized Representative; Privacy; Payments; Appointments

Assignment of Insurance Benefits -- Appointment as Legal Authorized Representative: I (i) assign all applicable health insurance payments and benefits, and all rights and obligations that I and my dependents have under my health plan to the Millennium Medical Management, LLC ("Provider"); (ii) authorize payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Provider; and (iii) appoint Provider as my authorized representative ("Authorized Representative") with the power to (i) file medical claims, appeals and grievances with the health plan; (ii) file appeals and grievances with the health plan; (iii) institute any necessary litigation and/or complaints against my health plan ***naming me as plaintiff in such lawsuits and actions if necessary*** (or me as guardian of the patient if the patient is a minor); and (iv) discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan. I also understand that Provider is not responsible for the terms of the contracts which I have with my health benefit plan or insurance companies. I certify that the health insurance and coverage information I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated. I am fully aware that having health insurance and/or Medicare coverage does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that (i) I am responsible for all amounts not covered by my health insurance and/or Medicare, including co-payments, co-insurance, and deductibles; and (ii) with respect to Medigap/Secondary Insurance, should my insurance or not pay all or part of the secondary balance, I am responsible for all remaining allowed charges.

Authorization to Release Information: I authorize my Authorized Representative and any holder of medical or other information about me to (i) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments (including the Social Security Administration or its Medicare Administrative Contractors if I am a Medicare beneficiary); (ii) process insurance and other payment claims generated in the course of examination or treatment; and (iii) allow a photocopy of my signature to be used to process insurance and other payment claims. This authorization will remain in effect until revoked by me in writing. I authorize Provider to discuss my **medical/health care** with the following family members or close friends:

Full Name:_____ Relation:_____ Phone:_____

Full Name:_____ Relation:_____ Phone:_____

Full Name:_____ Relation:_____ Phone:_____

I authorize Provider to discuss my **account finances** with the following family members or close friends:

Full Name:_____ Relation:_____ Phone:_____

Full Name:_____ Relation:_____ Phone:_____

Full Name:_____ Relation:_____ Phone:_____

ERISA Authorization: I designate, authorize, and convey to my Authorized Representative to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (i) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance police and/or benefit plan; and (ii) the right and ability to act as my Authorized Representative to pursue such claim, right or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.503-1(b)(4) with respect to any health care expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. This authorization will remain in effect until revoked by me in writing. A photocopy of this Authorization shall be as effective and valid as the original.

Payment Policy; Out-of-Network Disclosure/Patient Acknowledgment of Responsibility: I understand that (i) Provider accepts most forms of payment including checks, debit cards, credit cards and credit facilities like CareCredit and MedFin; (ii) Provider reserves the right to charge 1.5% interest per month, compounded daily, after 90 days of non-payment on all outstanding balances; (iii) credit cards and other revolving credit programs have chargeback provisions to allow, for example, return of purchased goods, but that such chargeback features are not appropriate at Provider, such that I waive my rights for chargebacks; (iv) if a chargeback occurs, Provider may initiate legal action to recoup the charges and I will be responsible for all resulting legal fees and other appropriate expenses to recoup those charges; and (v) Provider will assess a $50 fee on all checks that are returned as unpaid. I understand that Provider is an out-of-network provider and that, consequently: (i) I am responsible for the difference between charges and payments made by my health plan and any coinsurance and deductible required by my health plan; and (ii) Provider cannot waive any such patient responsibility.

Notice of Privacy Practices: I have reviewed the posted copy of Provider's Notice of Privacy Practices, which describes how my medical information may be used and disclosed and how I can obtain access to this information, and I understand that a copy for my records is available upon request.

Patient Name: _____

Patient Signature: _____ Date: _____

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. We understand that there are times when you may miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. If you must cancel an appointment we ask that you please call at least 24 hours prior to the appointment, or earlier if possible.

To cancel an appointment, call Patient Services at 321-751-3389 or 1-800-349-6922 (1-800-FIX-MY-BACK). Each cancellation or "no show" is tracked in our system and you will receive a cancellation number. Excessive cancellations and 'no shows' may require us to discharge you from the practice.

Cancellation Policy/No Show Policy
For Doctor Appointment and Surgery

1. ***Cancellation/No Show policy for Doctor Appointment***
   We understand that there are times when you miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

   If an appointment is not cancelled at least 24 hours in advance you will be charged a forty ($40) dollar fee; this will not be covered by your insurance company.

2. ***Scheduled Appointments***
   We understand that delays can happen however we must try to keep the other patients and doctors on time.
   If a patient is 15 minutes past their scheduled time we will either fit you in or give you the option to reschedule the appointment.

3. ***Cancellation/No Show Policy for Surgery/Procedures***
   Due to the large block of time needed for surgery, last minute cancellations will not allow time needed to schedule another patient in need of our services.

   If surgery/procedure is not cancelled at least 48 hours in advance you will be charged an eighty dollar ($80) fee; this will not be covered by your insurance company.

4. ***Account Balances***
   We will require that patients with no show/cancellation fees pay their account balances to zero ($0) prior to receiving further services by our practice.
   Patients who have questions about their bills or who would like to discuss the charges, may call the Office Manager and review their account and concerns.

_____ _____ ____/_____/_____
Print Patient Name **Signature Patient** **Date**

Patient Account # _____

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 **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 Orthopeadic Surgery and American Board of Psychiatry and Neurology.**

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 that 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 or Surgery Center of Viera, LLC, 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, employees of the physician or Surgery Center of Viera, LLC, 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	For any services not covered by Medicare, payment is also requested at the time of the visit. 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. 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	Accept you co-insurance amount, file the claim on your behalf including any claims to your secondary insurance.
Medicare HMO Fee-For-Service	All applicable co-payments at the time of the visit.	Accept your payment and file a claim to your insurance.
In Network HMO/PPO Plans	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.	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	All applicable co-payments and deductibles at the time of the visit.	Accept your payment and file a claim to your insurance.
Out of Network	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.	Accept your payment and courtesy file a claim to your insurance.
Self Pay	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. Credit, debit, check are accepted methods of payment. If you are a NEW patient please come prepared to pay by credit or debit.	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 $40 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.

Appointment Reminders are sent through email, phone calls, and optionally text. To receive text reminders, text the word NOTIFY to 37509