Millennium Wellness and Regenerative Medicine, LLC, Inc.

Notice of Privacy Practices, Patient Bill of Rights & Financial Policy

Patient Name:_____ Date of Birth:_____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I have certain rights to protect my health information. I understand that this information may be used to:

Conduct, plan, and direct my treatment and follow up among multiple healthcare providers who may be involved in my treatment directly or indirectly. Obtain payment from my insurance carrier. Conduct healthcare operations as per the Notice of Privacy Practice. _____(initial)

I have read and understand your Notice of Privacy Practices and Patient Bill of Rights and have been offered a copy of both notices. I understand that I may request in writing how my private information is used or disclosed to carry out treatment, payment, or healthcare options. I also understand that you are not required to agree to requested restrictions. _____(initial)

I authorize Millennium Wellness and Regenerative Medicine, LLC, Inc. and its representatives to discuss medical information, financial information, appointments and I give my consent to call/text me or my designated representative on the phone number(s) of record.

_____ (initial)

I understand that per the clinic financial policy, payment(s) and/or copays are due at the time of service unless prior arrangements have been approved. Our clinic accepts cash, check, Visa and Master Card payments. I understand that I have a contract with my insurance company and that we will file a claim on your behalf and that I agree to an assignment of benefits allowing us to receive payment for healthcare services. I also understand that if my claims are denied, I may receive a bill asking for payment of healthcare services, this includes non-covered charges. I understand this facility charges a $25.00 No Show Fee and a $25.00 Insufficient Fund Fee, per the practice policy.

_____ (Initial)

I understand my healthcare is under the direction of my Provider(s) and I will be well informed of my treatment and my treatment options. I further understand that I will be given patient education material and information regarding my diagnosis and that no guarantees have been made to me regarding the outcomes of my treatment.

I have read and understand these notices and statements of policy and I agree to be bound by those terms. I also understand that these notices and statements may be amended and/or are subject to change.

Patient Signature: _____ Date: _____

Printed Name: _____ Date: _____