Millennium Wellness, LLC and Millennium Regenerative Medicine, Inc.

Patient Demographic and Insurance Intake Form

Last Name: _____ First name: _____ MI: _____

Date of Birth: _____ Sex: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

Email: _____

Primary Care Physician Name: _____

Employer: _____ Phone: _____

Medications/Vitamins/Supplements: _____

_____

_____

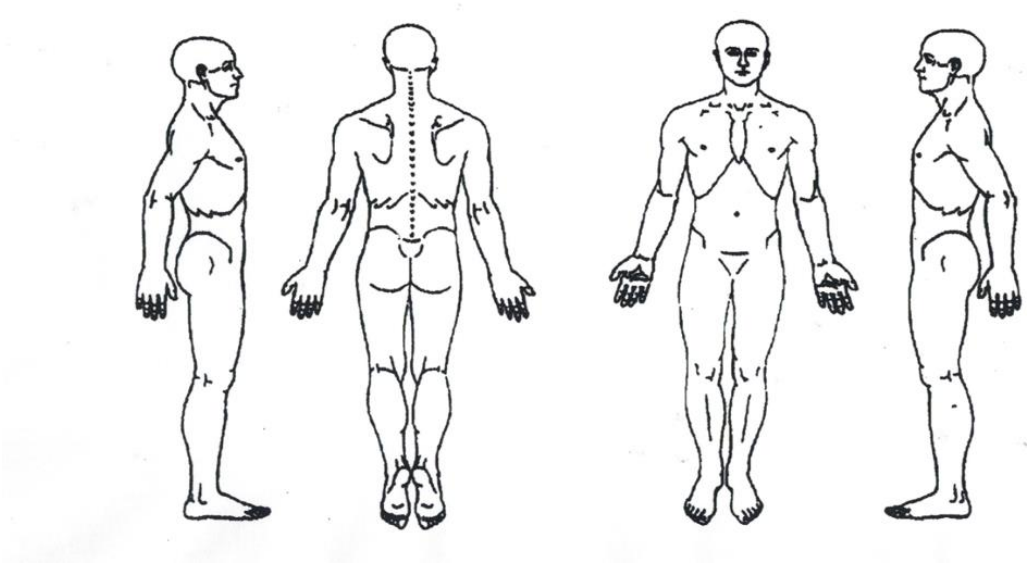
Medication Allergies: _____

Emergency Contact: _____ Phone _____

What is your chief complaint? _____

Shade in all areas of pain. Grade the intensity of pain in each area using 0 - 10 scale:

0 = no pain / no discomfort, 10 = the worst pain you can imagine



Medical History

Have you ever been diagnosed or treated for the following? (**if yes, please specify**):

Yes or No Heart Disease? _____

Yes or No High blood pressure? _____

Yes or No Cancer? _____

Yes or No Diabetes? _____

Yes or No Thyroid disease? _____

Yes or No Kidney disease? _____

Yes or No Gastrointestinal disease? (stomach, colon, liver, etc.) _____

Yes or No Infectious diseases? (hepatitis, TB, AIDS, Lyme) _____

Yes or No Major Surgery (Please List) _____

Yes or No Difficulty with healing of wounds? _____

Yes or No Any keloids, bad scars or excessive bleeding? _____

Are you currently taking any blood thinners or have any history of excessive bleeding? _____

I have read and understand the HIPAA policy and Privacy Notice. I have been offered a copy of this notice. I hereby assign my insurance benefits to be paid directly to my healthcare provider. I authorize Millennium Wellness, LLC and Millennium Regenerative Medicine, Inc. to bill my insurance and release medical record information. I consent to treatment of services rendered by my Provider and/or staff members. I understand services rendered may not be an insurance benefit and that I am responsible for non-covered services. Payment is due at the time of service. I am responsible for any balance on my account. I authorize my Provider's office to contact me by mobile phone, email or text message.

To the best of my knowledge the above information is complete and accurate.

Signed: _____ Date:_____

Parent/Guardian Signature (if minor): _____ Date: _____

General Pain Index Questionnaire

We would like to know how much your pain **presently** prevents you for doing what you would normally do. Regarding each category, please indicate the **overall** impact your present pain has on your life, not just when the pain is at its worst.

*Please **circle the number** which best describes how your typical level of pain affects these six categories of activities.*

1. Family / At-home responsibilities such as yard work, chores around the house or driving the kids to school –

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

2. Recreation including hobbies, sports or other leisure activities –

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

3. Social activities including parties, theater, concerts, dining-out and attending other social functions –

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

4. Employment inducing volunteer work and homemaking tasks –

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

5. Self-Care such as taking a shower, driving or getting dressed –

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

6. Life-Support activities such as eating and sleeping –

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

Patient Name: _____ **Date:** _____

Score: _____ (60)

Mandatory Disclosure Statement

Tim Hawbaker is a Family Nurse Practitioner and a Licensed Acupuncturist. Christin Hawbaker is a Licensed Acupuncturist and a Certified Massage Therapist.

At Millennium Wellness we only use sterile, disposable needles. We are in compliance with the standards set forth by the Department of Public Health. No license, certificate or registrations has ever been revoked or suspended.

We accept Medicare, Workman's Comp Insurance, Veterans Administration Insurance and several private insurances.

Fee Schedule

Acupuncture: $85.00	Prolozone Injections: $150.00
Massage 60 min - $75.00	Ozone Sauna: $55.00 (package of 10 $450)
Massage 90 min - $105.00	Ozonated Water: $25.00 / refills $20.00

I. You are entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy.
II. You are entitled to seek a second opinion from another healthcare provider, or terminate therapy at any time.
III. Sexual intimacy is never appropriate in a professional relationship and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

The practice of Acupuncture is regulated by the:
Colorado Department of Regulatory Agencies
1560 Broadway, Suite 1340
Denver, CO 80202-5146
Telephone: 303-894-7851

MEDICARE INSURANCE BILLING

If you are a Medicare patient, your yearly deductible needs to be met before Medicare will pay for your treatments.

Medicare plans have deductibles just like individual or employer health insurance plans do. Medicare requires you to meet a deductible, an amount you pay for healthcare or for prescriptions before your healthcare plan begins to pay. This means that if the providers at Millennium Regenerative Medicine are the first health care providers that you have seen this year, you will be responsible to first pay your deductible before Medicare will pay for any of your treatments.

The annual **deductible** for all **Medicare Part B** beneficiaries is **$203.00** in **2021.** This will be met within one or two visits. Once your deductible is met, Medicare generally pays 80% of your healthcare bills which means you will be responsible for 20%. This means that the majority of your treatments at Millennium Regenerative Medicine will cost you between $15.00 to $25.00 out of pocket per treatment. If you have a supplemental plan or a Medigap Insurance Policy, this typically pays for much of the 20% that Medicare does not cover.

We do not accept Medicare Advantage Plans (Part C) such as Humana, Rocky Mountain or Anthem PERA.

WE DO NOT ACCEPT ANY FORM of MEDICAID. If you are a Medicare patient with one of these Medicare supplements you will be responsible for your initial deductible of $203.00 and the 20% Medicare does not cover on your follow up visits.

This is a medical practice so our billing is going to reflect that of a medical practice. You can expect to see charges that are similar to your primary care physician for each visit to our office if you choose to use your Medicare benefits.

We do not do billing in house. If you have any questions about your billing you can contact Billing Solutions, Inc. at (970) 240-8822.

Signature: _____ Date:_____

Millennium Wellness, LLC & Millennium Regenerative Medicine, Inc.

Notice of Privacy Practices

HIPPA Notice of Privacy Practices. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully and request a copy for your records.

This notice describes how we may use and disclose your protected health information to carry out treatment, payments or healthcare operations and for other purposes that are generalized by law. It also describes your rights to access and control your protected health information. Protected health information (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present and future health conditions or related healthcare services.

We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services, including supplies and prescriptions. Your information may be given to other Providers that treat you may include other Physicians, physician assistants, nurse practitioners, nurses, office staff and medical equipment providers.

Your protected health information will be used as needed to obtain payment for your healthcare services. This may include certain activities that your health plan may undertake before it approves or pays for healthcare services, we recommend for you, such as making a determination of eligibility of coverage for insurance benefits and reviewing services provided to you for medical necessity for continuum of care.

We may use or disclose your protected health information for use or disclosure during healthcare operations that may improve the quality of your healthcare, or for population disease management. At times, federal, state and local laws require us to disclose patients' medical information. We are required to report abuse, neglect and communicable disease. Communicable disease reporting requires us to obtain a written release of information prior to reporting. We may release for information for public health and safety. We may also disclose your protected information for other healthcare providers for the purpose of education and learning purposes.

We may use and disclose your protected health information to contact you and remind you of an appointment for treatment or medical care, or to contact you to discuss possible treatment options or alternative health related benefits and services that may benefit you.

We may disclose your protected health information if it is ordered by a court or we receive a subpoena or a search warrant for records. You will be notified in writing, in advance to the best of our ability. You have the right to request revocation and/or object to the request as dictated by Arizona state and federal government law.

You have the right to request a paper copy of your medical records. You have the right to request an amendment to your protected health information. You have the right to confidential communication regarding your healthcare. You have the right to request restrictions on how we disclose your protected health information.

You have a right to request a copy of this notice for your records. You have the right to request updates or changes to these rights.

Millennium Regenerative Medicine, LLC and our Practitioners are covered by this notice. We are required by law to provide you of a copy of this notice. We are required by law to post this notice. Do you have a complaint? Please contact Tim Hawbaker, FNP or designee during business hours at 970-856-4729.

Patient Signature: _____ Date: _____

Printed Name: _____ Date: _____

Millennium Wellness, LLC and Millennium Regenerative Medicine, Inc.

Clinic Financial Policy

Policy:

It is our policy that we will address patient payment standards, participating insurance acceptance and coverage. Best practice accounting principles including late fee's, returned check fee's, no show fee's, assignment of benefits and billing practices following Center for Medicare Services (CMS)regulations.

Procedure:

Payment (copay/coinsurance/deductible) is expected at the time of service. We accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment, or non-covered charges from your insurance company. If you are a cash / self - pay patient payment in full is expected at the time of your visit. We do ask for a copy of an ID card or license.

Insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period, the patient will be billed. If we later receive payment from your insurer, we will refund any overpayment to you. At this time, we accept Medicare, VA, and Pinnacol Assurance – Worker's Comp. For patients with private insurance we require payment upfront at the time of service and we are happy to provide you with a superbill that you can submit to your insurance company for reimbursement.

LATE CHARGES of 12% annually will be applied to all patient balances 90 days old or greater.

RETURNED CHECKS will incur a $25.00 service charge. We will ask our patients to bring cash, certified funds or a money order to cover the amount of the check plus the $25.00 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $25.00 service fee and collections action.

If our patients have any questions regarding any billing statements, they will be instructed to call our biller. Billing Solutions 970-240-8822.

CANCELLATIONS OR MISSED APPOINTMENTS: If the patient does not cancel their scheduled appointment at least 24 hours before, or if the patient is considered a no-show, we will assess a $25.00 missed appointment fee. Per this policy, a patient will be considered a No Show when she/he is more than 20 minutes late with no notification.

Our patients further understand that they authorize and direct Millennium Regenerative Medicine, Inc. to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

Patient Name: _____

Signature: _____

Patient Representative: _____

Date:_____

Patient Bill of Rights & Responsibilities

Millennium Wellness, LLC and Millennium Regenerative Medicine, Inc

YOU HAVE THE RIGHT TO:

1. Receive considerate and respectful care, to be made comfortable. You have the right to respect your cultural, psychosocial, spiritual, religious and personal values, beliefs and preferences without discrimination.
2. Receive confidential medical treatment. Receive a copy of the Notice of Privacy Practices and that all communications are considered confidential. Receive educational information in order to make informed choices about your health care.
3. Receive information about your Provider who has the responsibility of coordinating your care. You have the right to receive information about other healthcare professionals, non-physicians involved in your care as well as names and titles of those individuals caring for you.
4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of your care. You have the right to receive this information in terms you can understand so you can participate in your care. You have the right to refuse treatment. You have the right to conflict resolution. You have the right to designate a decision maker on your behalf.
5. Make decisions regarding medical care and receive as much information about any proposed treatment and/or procedure that you will need in order to make an informed consent or to refuse a course of treatment. This information will include a description, treatment, significant risks involved and alternate courses of treatment. You have the right to request or refuse treatment from a provider(s) or hospital(s) as allowed by law except in an emergency. You can expect privacy, respect and dignity during your discussions regarding your healthcare, examination and treatment.
6. Appropriate assessment and management of your pain, information about pain and pain relief measures and to participate in your treatment decisions and options. You may request or reject the use of any or all modalities to relive pain.
7. Receive information about your follow up care, discharge or transfer of your care.
8. Participate in discussions about any ethical issues that may affect your care. You may refuse to consent to photographs being taken, other than identification for diagnosis and treatment. You may agree or refuse to participate in research or experimental research, trial treatments in regards to your care.
9. You have the right to file a grievance against this facility, Provider or employee(s) by contacting Tim Hawbaker, FNP during office hours. You may also file a complaint with the Colorado Department of Health Services online.
10. Receive information about your billing process and charges. You can request a copy of the facility and provider fee schedule at any time.

11. Receive quality healthcare in a safe and private setting free from constraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.

12. Exercise these rights without regards to sex, race, color, religion, ancestry, national origin, age, disability, medical condition, marital status, sexual orientation, educational background, economic status or the source of your payment for care.

PATIENT RESPONSIBILITIES INCLUDE:

As our patient, your responsibilities include providing our staff with complete and accurate information regarding your condition, past medical history, social history, hospitalizations, medications (including over the counter vitamins and supplements), and all other information related to your healthcare. Follow your Practitioners orders and instructions at all times. Accept responsibility for refusing treatment or following all healthcare management protocol recommendations.

Your healthcare information will be protected and only released with a written consent. Please be considerate of other patient's privacy and the need for a quiet, uninterrupted healing environment.

If you do not understand your treatment plan for healthcare plan, please request additional information or explanations about your health status.

Provide office staff with updated information regarding your demographics, insurance contact phone number and emergency contact information.

Report any observations of concern to office staff or Tim Hawbaker, FNP. 970-856-4729

Patient Signature: _____ Date: _____

Printed Name: _____ Date: _____