Advanced Medicine & Longevity Center, L.L.C.
Michael G Milton, MD
6030 Bethelview Rd, Ste 403
Cumming, GA 30040
770-205-6068 Fax 770-205-8470

Name:(Last, First, Middle Initial)_____
Address:_____
City_____State_____Zip Code_____
Telephone Number_____ Work Number _____
Cell Number: _____ E-Mail Address: _____
Date of Birth_____ Age _____Sex_____
Marital Status_____ Occupation _____
Pharmacy Name and Zip _____ Pharmacy Phone and Fax # _____

Referred By_____

Please list your top three health concerns:

_____
_____
_____
_____

Please list any previous surgeries or hospitalizations:

_____
_____
_____

Please list all current medications, vitamins and herbs that you are currently taking:

_____
_____
_____
_____

Please list all drug allergies and reactions:

_____
_____
_____

Please list all past diagnoses, medical problems and illnesses:

_____
_____
_____
_____
_____
_____

Please list medical problems that occur in your immediate family:

_____
_____
_____

For Women: Menstrual History Age of Onset_____ o Regular o Irregular Days of Flow___ Last Period ____
o Bloating o Cramping Number of Pads/Tampons Daily___
Have you ever been pregnant? o Yes o No Number of Pregnancies____ Number of Children_____
Have you ever had any abnormal Pap smears or Mammograms? o Yes o No

For Men: Do you have any difficulty urinating? o Yes o No
Do you have to get up in the evening to urinate? o Yes o No

For Children: Immunizations up-to-date? o Yes o No
Birth Weight_____ List any Birth complications _____

List any health or developmental concerns_____
_____

List any health risks: _____
_____

Do you snore?_____
Do you smoke?_____ How much?_____ How many years?_____
Do you drink alcohol?_____ How much?_____ How many years?_____
Has drinking ever affected your job or home?_____
Have you ever used street drugs?_____ What types?_____
Do you regularly use seat belts, car seats and bike helmets?_____

Sense of Well-Being:
Are you generally pleased with your life? _____
Do you have a sense of inner well-being and contentment?_____
What life stresses concern you most?_____
Would you like stress management, biofeedback or lifestyle counseling? _____

Fee for Service and Insurance Information: We are asking that patients care for their fees at the time of their appointment. It would be our pleasure to provide you with the documentation you need to be reimbursed by your insurance company. Insurance companies frequently respond to their client (you) more quickly than they do us. Most of our patients have found that by placing their fee on a credit card they will receive reimbursement by the time their statement arrives. Dr. Milton is totally committed to your health and to providing only what is best for YOU, not what is dictated or limited by an insurance company. This allows Dr. Milton to practice the best of all possible medicine.

EMERGENCY INFORMATION:

Name_____ Relationship _____
Telephone Number_____
Address_____
Employer_____
Work Phone Number_____

I hereby authorize Advanced Medicine & Longevity Center, L.L.C. and Dr. Milton to administer medical treatment to _____. I also authorize the release of any medical records necessary in my treatment.

Witness_____ Patient _____
(Date) (Date)

Office procedures and fee schedule for Advanced Medicine and Longevity Center, LLC

www.drmilton.net office@drmilton.net **P: 770-205-6068** **Fax: 770-205-8470**

Office hours: All visits are by appointment only. Our office hours are Monday through Thursday, 9 a.m. to 12 noon and 2 p.m. to 5 p.m. and Fridays by appointment.

Appointments: If you are a new patient please download a health questionnaire and bring it to your appointment. Arriving 10 minutes prior to your scheduled appointment time allows you to handle any paperwork or updates to your records. Please know that while we understand that life can be unpredictable, we may not be able to accommodate last minute changes or late arrivals. **To avoid a missed appointment fee when rescheduling an appointment we require a 48 hour (2 business days) notice.** These will be applied to your CC on file or billed to your account.

Emergencies: In case of an emergency call 911 or go to your nearest emergency room. For urgent medical problems that arise after hours please call the office and follow the instructions on our voicemail.

Letter and Record Requests: Copies or transfer of records is $30 or more depending upon the size of the record. Letter requests are $25. Legal requests begin at $50.

Fee for Service and Insurance Information: Dr. Milton is totally committed to your health and to providing only what is best for YOU, not what is dictated or limited by an insurance company. This allows Dr. Milton to practice the best of all possible medicine, so fees are handled in full at the time of your appointment. It is our pleasure to provide you with the documentation you need to be reimbursed by your insurance company. For your convenience we accept Master-Card, Visa, American Express, and Discover.

Medical Records: To reduce unnecessary testing, please bring with you any recent (6 months or less) lab work, EKG's or X-rays.

Prescriptions: Please bring all prescriptions with you to each office visit so that we can review your medications. Any refills should be handled at the time of your office visit. **For your protection, it is our policy for you to have been seen by Dr. Milton in person in the past twelve months to have prescriptions called in**. Certain conditions also require lab testing for refills on at least yearly basis, and sometimes earlier. Please be aware of your individual needs to avoid any interruptions in your medications.

Out-of-State & Out-of-Country Patients: When possible we will arrange phone consultations for out-of-state and out-of-country patients in lieu of office visits, however, **all patients need to be seen in-person at least once per year** for Dr. Milton to continue to provide care for you.

Fee Schedule: While fees may vary on an individual basis, the following is provided as a guideline for determining expected fees for services provided at Advanced Medicine. Fees are subject to change without notification.

Physician Services:	Initial Office Visit: Begin at $395 Follow-up Visits: Begin at $185 Osteopathic Adjustments/Myofascial Treatments: Begin at $90. Packages of 4 are $270. Phone Consultations: up to 10 minutes = $145, 15 minutes = $165, 20 minutes or more begin at $185 Emails requiring Chart Review or Medication Adjustments: Minimum fee of $75 based on time involved
IV Treatments:	Chelation IV: $75 Nutrient IV: $75-150 unless otherwise specified IV push vitamins: $75
Prolotherapy:	Joint Injection: $150 per joint per session Neck, shoulder and head area: $300-450 total per session Back: $300-450 total per session

Patient Bill of Rights:

- To seek consultation with the physician (s) of their choice;
- To contract with their physician (s) on mutually agreeable terms;
- To be treated confidentially, with access to their records limited to those involved in their care or designated by the patient;
- To use their own resources to purchase the care of their choice;
- To refuse medical treatment even if it is recommended by their physician (s);
- To be informed about their medical condition, the risks and benefits of treatment and appropriate alternatives;
- To refuse third-party interference in their medical care, and to be confident that their actions in seeking or declining medical care will not result in third-party imposed penalties for patients or physicians;
- To receive full disclosure of their insurance plan in plain language.

Initial here to acknowledge receipt of this form : _____

Patient: _____ Date: _____

DISCLOSURE AND CONSENT FORM

To the patient (And others legally responsible for the patient): You have the right, as a patient, to be informed about your condition and how integrative and alternative medicine may be applied in a treatment plan. This disclosure is intended to provide an opportunity for you to make an informed decision so that you may give or withhold your consent to treatment that may be considered unconventional by physicians trained only in the United States.

NOTICE: Refusal to consent to the integrative and alternative procedure(s) shall not affect your right to future care or treatment.

I voluntarily request that Dr. Michael G. Milton, and other affiliated health care personnel as he may deem necessary, treat my condition(s) (or the condition(s) of the person for whom I am responsible).

I understand that some of, or all of, the following integrative and alternative treatments are planned for me (or the person for whom I am responsible), and I voluntarily consent and authorize the following: Administration of Homeopathic remedies, herbal and nutritional therapies, off-label use of pharmaceuticals, Neural therapy, Prolotherapy, Intravenous nutritional therapies, Oxidative therapy, physical and/or quantum physical modalities (including osteopathy, light, color, electromagnetic and magnetic therapies) and extended neurological examination including neuromuscular and autonomic nervous system response.

I understand that no warranty or guarantee has been made regarding results of treatment. I realize that there may be risks and hazards in treating this present condition, with or without conventional medicine, and there may also be risks and hazards related to the planned integrative treatment, including worsening of present symptoms, development of new symptoms (especially detox or herxheimer reactions) and undesirable interactions between various treatments, both conventional and integrative.

I have been given an opportunity to ask questions about the treatment of this health condition using conventional, integrative and alternative methods. I have had an opportunity to discuss the possible risks and hazards of treatment and non-treatment, and I believe that I have sufficient information to give this informed consent. I certify this form has been fully explained to me, that I have read it (or have had it read to me), that the blank spaces have been filled in, and that I understand its contents. I also certify that Dr. Milton has provided this Disclosure and Consent Form to me and fully explained the diagnostic and treatment options available, and has made no guarantees to me as to the success of this treatment. This consent will remain in effect until certified written notice of withdrawal is presented.

SIGNATURE OF PATIENT OR OTHER LEGALLY RESPONSIBLE PERSON REQUIRED BELOW:

SIGNED: _____
PRINT NAME ONLY IF OTHER THAN LEGALLY RESPONSIBLE PERSON:

_____DATE:_____TIME:_____AM/PM

WITNESS SIGNATURE: _____
6030 BETHELVIEW ROAD, SUITE 403, CUMMING, GEORGIA

ADVANCED MEDICINE

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Advanced Medicine, 6030 Bethelview Rd., Suite 403, Cumming, GA 30040. Phone: 770-205-6068

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

OPTIONAL:
4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

OPTIONAL:
5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

OPTIONAL:

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL:
7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

OPTIONAL:
5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

OPTIONAL:
6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

OPTIONAL:
7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **[insert name, or title, and telephone number of a person or office to contact for further information]** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **[insert name, or title, and telephone number of a person or office to contact for further information]**. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **[insert name, or title, and telephone number of a person or office to contact for further information]** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **[insert name, or title, and telephone number of a person or office to contact for further information]**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **[insert name, or title, and telephone number of a person or office to contact for further information]**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **[insert name, or title, and telephone number of a person or office to contact for further information]**.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact [**insert the name, title, and phone number of the contact person or office responsible for handling complaints**]. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Advanced Medicine, 6030 Bethelview Rd., Suite 403, Cumming, GA 30040. Phone: 770-205-6068

Advanced Medicine & Longevity Center, L.L.C.

Michael G. Milton, MD
6030 Bethelview Rd.
Suite 403
Cumming, GA 30040
Office: 770.205.6068 Fax: 770.205.8470

Date: _____ Patients Name: _____

Initial

_____: I have received a copy of Advanced Medicine's Notice of Privacy Practices (HIPAA)

_____: I consent to allow Dr. Milton and staff to discuss my health issues with friends or family members or other health professionals that I have contact the office on my behalf.

_____: I specifically also allow these listed people to discuss my health issues with Dr. Milton and staff:

_____

_____

_____

_____: I do not wish to have my health issues discussed with anyone other than myself. *(Only check this line if you are excluding the above 2 HIPAA consents*)

_____: I have read and agree with the Disclosure and Consent form.

_____: I have read and agree with the Policies and Procedures of Advanced Medicine.

Patients Signature Date