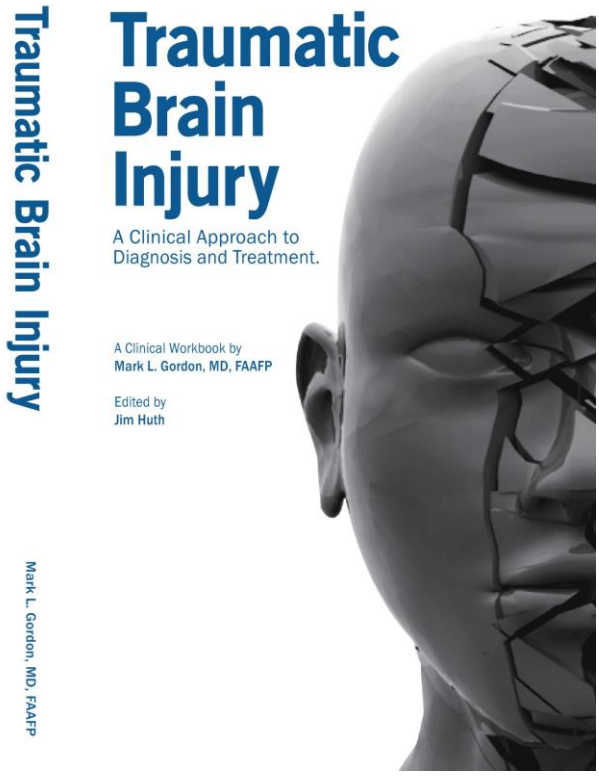
Millennium TBI Network

Rebuilding Hope one day at a time



NEW PATIENT INFORMATION PACKET – CIVILIAN TBI

TBI Enrollment_2018.01

WELCOME

You have identified yourself as an individual seeking enrollment into our Traumatic Brain Injury program. This short packet contains the most important documents needed to start your evaluation. Once you have completed this packet please email it back to drboch@gmail.com

: Dr. Angelo Baccellieri

: Westchester Wellness Medicine

Millennium TBI Network

Rebuilding Hope one day at a time

Instructions for Non-Service Personnel Enrollment Packet

This **Enrollment Packet** consist of documents needed to establish a medical record based upon knowledge of your medical history (past and present) which will be used to write up your consultation and laboratory report and to provide a customized treatment protocol. **These documents can be filled out on screen and then saved to your computer before attaching to an email or faxing to our office**. In the future, we may provide you with additional documents.

The first page following these instructions is an Out of State Disclosure form. This lets you know that we need to have a physician in your state to write any of the prescription medications we recommend. We are presently training physicians in other states to provide assessment for TBI. Please make sure that you put your name on each space that asks for it and fill out the Enrollment Packet to the best of your ability.

A credit card authorization form is included which needs to be completed for us to open your case and to arrange for your blood draw. We are a cash only facility and do not have an insurance department. No charges will be placed on your Credit Card until a member of our office calls you and answers your questions. Only after you agree to enter the program will the charges be made so we can start your program by ordering labs.

At the end of the packet is an "INFORMED CONSENT FOR THE USE OF TELEMEDICINE". This will allow us to communicate via Skype in order to provide a Physical-Patient Interaction that is LIVE but virtual. Otherwise, you will be required to come into the office.

The remaining documents are import medical history and mental health questionnaires. These will act as a record of your baseline which will be assessed repetitively throughout your treatment protocol. You will also fill out a" **History of Injury**" report. If there have been multiple traumas or injuries in the past please indicate them in the "**Summation of Injuries"**, and only fully report on the case(s) under litigation. Please be as concise as possible.

Finally, please go to our website westchesterwellnessmedicine website to obtain answers and information on the most commonly asked questions or requested information. If you cannot find the answers, please email the office in lieu of calling. Once you have submitted your completed Enrollment Packet, someone in the office will call you at which time you can clarify any issues. Please be advised that there is a waiting list and backlog of patients requesting services. We are trying to minimize waiting time so if your Enrollment Packet is complete, we can accept you into the program more rapidly. Present waiting time is about 1 Week.

Email and Fax to us:

drboch@gmail.com or FAX 914-703-4810

I look forward to reviewing your results with you soon.

All the best

Millennium-TBI Project

Millennium TBI Network

Rebuilding Hope one day at a time

Disclosure of limitations of Medical Care for Out of State Clients

The remote or local services provided by the Millennium Health Centers, Millennium-TBI Project, or Millennium-Warrior Angels Foundation consist of an initial laboratory evaluation for traumatic brain injury (TBI). The result of this evaluation is reported to the client with a written report which is followed by a Skype or in person review and consultation for a recommended treatment protocol. At the present time, we are only licensed in California and Florida for the practice of medicine. Therefore;

1. ___ We are limited in the ability to prescribe medication to clients in other states unless they have traveled to the office in Encino, California for a face-to-face consultation. Thereafter, the client can be called a California patient with the ability to have prescription medication provided directly to them. **If you are willing to travel to the office, please select this option**.

2. ___ If you are not able to travel to the Encino office, then the Millennium can arrange for the laboratory testing and provide a comprehensive report and treatment consult. The Millennium will be able to dispense all non-prescription products while your personal physician would be asked to write for prescribed medication. The Millennium Health Centers will provide over-sight and the program supplements as indicated in your report. You may also, obtain these from any other source and not just from us.

3. ___ At present, we are working to build a network of Millennium-TBI trained physicians in every state so that they can provide you with the same level of care as we do at the Millennium Encino offices. Going to www.tbimedlegal.com and selecting TBI-Network Physicians, will give you a list of participating healthcare providers that have completed our program. We can still offer you our services up until the writing of prescriptions if desired and then like Option 2, send the final report and instructions to your physician or a Millennium-TBI trained healthcare provider.

4. ___ This does not apply to me since I live in California/Florida.

Please select one of the above options and sign the statement below. This needs to be completed before you are accepted for enrollment into the program.

I, _____, have read the above program options understanding that I will not be dispensed any prescription medications if I live outside of California/Florida and that I will have to arrange for medication from my healthcare provider(HCP). The Millennium will provide documentation to my HCP after I have signed-off with a HIPPA release form.

STATE: [ ]

Signature and date and State.

16661 Ventura Blvd, Suite 716. Encino, CA 91436. **Fax**: 818-990-2841 or
Clientliaison@millenniumhealthcenters.com

Millennium TBI Network

Rebuilding Hope one day at a time

Your full name (F M L)	
Street Address1	
Street Address 2	
City	
State and Zip	
Contact Phone #	
Contact Email	
Your Credit Card Type	___AMEX ___VISA ___MasterCard ___Discover
Credit Card Number	
Expiration Date	
CVV or Code on back	
Credit Card Zip Code	
***Standard TBI Evaluation**	☐ $

I authorize _____ and or their representative to charge my credit card in the amount indicated above based upon the program I have selected (marked).

Digital Signature: DATE:

Once your Enrollment Packet has been submitted to the office it will be reviewed for enrollment in the program you have selected. Only after we contact you will the card be charged and the laboratory services ordered for your initial evaluation.

Additional Comments:

Contact:

Confidential Health Questionnaire

DATE:

Personal Information

Millennium-TBI Project @ www.TBImedlegal.com

First Name:	Last Name:	Age:	Gender:
Social Security Number: DO NOT ENTER	Date of Birth:	Marital Status:	Refferal Source:
Street Address:	Zip Code:	City:	State:
Best Contact Phone Number:	2nd Best Contact Phone Number:		
E-mail Address:	Preferred Method of Contact:	✔ if Ok to Leave Message: ☐ Phone ☐ Email	

Medical History

Please check any medical condition or health problem that you and your family currently have or have had in the past.

Medical Condition	Self		Family	
	Yes	No	Yes	No
Heart Attack				
Angina (Chest Pain)				
Palpitations				
Irregular Heart Rhythm				
Heart Failure (CHF)				
Heart Valve disorder				
Stroke				
Transient Ischemic Attack				
Vascular Disease				
Blood Clotting Problems				
Bleeding Disorder				
High Blood Pressure				
Diabetes Mellitus (DM)				
High Blood Sugar (100-125)				
Abnormal Cholesterol				
Obesity/Overweight				
Thyroid Disorder				
Shortness of Breath				
Asthma				
COPD				
Chronic Bronchitis				
Lung/Breathing Problems				
Sleep Apnea				
Pulmonary Hypertension				
Seizure Disorder				

Medical Condition	Self		Family	
	Yes	No	Yes	No
Insomnia				
Dementia				
Liver Disease				
Gallbladder disease/stones				
Ulcers				
Colitis				
Chronic Constipation				
Chronic Diarrhea				
Kidney Disease or stones				
Chronic Indigestion				
GERD (Reflux Disease)				
Osteopenia or Osteoporosis				
Osteoarthritis				
Rheumatoid Arthritis				
Gout				
Chronic Muscle/Joint Pain				
Neck Pain				
Shoulder Problems				
Back Pain/Sciatica				
Herniated Disc				
Fibromyalgia				
Chronic Pain				
Tendonitis				
Cancer				
Recurrent sinus infections				

Medical Condition	Self		Family	
	Yes	No	Yes	No
Migraines or Headaches				
Dizziness				
Loss of Consciousness				
Depression				
Anxiety				
Eating Disorder				
Emotional/Psychiatric Illness				
Alcohol Abuse				
Drug Abuse				

Medical Condition	Self		Family	
	Yes	No	Yes	No
Seasonal Allergies				
Eczema				
Psoriasis				
Skin Problems				
Sexual/Libido Problems				
Prostate Problems				
Reproduction Problems				
Sexually Transmitted Dx				

☐ Check if you and your family do not have any other medical conditions or health problems other than those listed above.

List any other medical conditions or health problems not listed above that you and your family currently have or have had in the past.

1)	2)	3)
4)	5)	6)

Please give detail of all PERSONAL medical conditions and health problems.

☐ Check if you do not have any medical problems

Medical Condition	Date of Diagnosis	Description
1)		
2)		
3)		
4)		

Please give detail of all FAMILY medical conditions and health problems.

☐ Check if there is no family history of medical problems

Medical Condition	Relation	Date of Diagnosis	Description
1)			
2)			
3)			
4)			

Allergies to Medications ☐ Check if No Known Drug Allergies

Medication Name	Reaction
1)	
2)	

Allergies to anything else (food, environmental, latex, etc.)

☐ Check if you don't have allergies

Allergy to:	Reaction
1)	
2)	

Please list prescription medications currently being used.

☐ Check if you are not using prescription medications

Medication Name	Dosage and Frequency	Date Started	Reason for Use
1)			
2)			
3)			
4)			

Please list prescription medications used in the last year which you are no longer using. Start with the medications which were most recently stopped.

☐ Check if you haven't used prescription medications in the past

Medication Name	Dosage and Frequency	Date Started	Date Stopped	Reason Used
1)				
2)				
3)				
4)				

Please list supplements and over-the-counter medications currently being used.

☐ Check if you are not using supplements and over-the-counter medications

Medication Name	Dosage and Frequency	Date Started	Reason for Use
1)			
2)			
3)			
4)			

Please list all past SURGERIES.

☐ Check if you have not had surgery in the past

Surgery	Date of Surgery	Reason for Surgery
1)		
2)		
3)		
4)		

Personal & Social History.

Occupation:	Employer:	Stress Level at Work (10=highest)	Describe Work Stressors:
Marital Status:	# Living Children:	Stress Level at Home (10=highest)	Describe Home Stressors:

Use of Alcohol: ☐ Yes ☐ No	Type of Alcohol:	Amount:	Start Date:	Stop Date:	Duration:
Tobacco: ☐ Yes ☐ No	Cigarettes/day:	Other Tobacco:	Start Date:	Stop Date:	Duration:

Street Drug Use: ☐ Yes ☐ No	Type of Drug:	Amount:	Start Date:	Stop Date:	Duration:
Sexually Active: ☐ Yes ☐ No	Sexuality:	# of Partners:	Unprotected Sex: ☐ Yes ☐ No	Contraception:	Duration:
Hobbies/Interests:					

OB/Gyn History (Female patients)			
Last Menstrual Period:	Age During Onset of 1st Period:	PMS Symptoms: ☐ Yes ☐ No	Cycle Duration:
Check if you have any of the following: ☐ Heavy Bleeding ☐ Spotting ☐ Pain ☐ Irregularity		Describe:	

Are you pregnant: ☐ Yes ☐ No	Are you breastfeeding: ☐ Yes ☐ No	Are you trying for a pregnancy: ☐ Yes ☐ No			
# of Pregnancies:	Vaginal:	C-section:	Miscarriages:	Abortions:	Other Complications:

Review of Systems

Please check YES to any symptom that you experience. For any YES answer please provide a brief description

Symptoms	No	Yes	If YES, List Doctor Seen, Describe Condition and How Long
Fever/Chills	☐	☐	
Execess Fatigue	☐	☐	
Weight Loss/Gain	☐	☐	
Enlarged Lymph Nodes	☐	☐	
Frequent Bruising	☐	☐	
Blurry Vision	☐	☐	
Ringing in Ears	☐	☐	
Hearing Difficulty	☐	☐	
Mouth Sores	☐	☐	
Sinus Problems	☐	☐	
Cardiovascular:	**No**	**Yes**	
Chest Pain at Rest or Exercise	☐	☐	
Cold hands/Cold Feet	☐	☐	
Swelling of Legs	☐	☐	
Gastrointestinal:	**No**	**Yes**	**# Bowel Movement /Day**
Constipation	☐	☐	
Diarrhea	☐	☐	
Bloating	☐	☐	
Exessive Belching	☐	☐	
Gas/Acidity	☐	☐	
Blood in Stool	☐	☐	
Thirst: Lack of /Too Much	☐	☐	**# Glasses of Fluid/Day**
Genitourinary:	**No**	**Yes**	
Pain on Urination	☐	☐	
Cloudy/Bloody Urination	☐	☐	
Urinating Too Many Times	☐	☐	**# Times per Day**
Difficulty Urinating	☐	☐	
Loos of Urine	☐	☐	

Musculoskeletal:	No	Yes	If YES. please Rank PAIN Severity
Do you see a Chiropractor?	☐	☐	
Any Regular Body Treatment Massage?	☐	☐	
Back Pain	☐	☐	
Neck Pain	☐	☐	
Shoulder Pain	☐	☐	
Arm Pain	☐	☐	
Hip Pain	☐	☐	
Knee Pain	☐	☐	
Other pain	☐	☐	
Muscle Point Tenderness (pls. Describe)	☐	☐	
Skin:	**No**	**Yes**	
Acne	☐	☐	
Dry Skin	☐	☐	
Oily skin	☐	☐	
Loss of Collagen/Firmness	☐	☐	
Wrinkles	☐	☐	
Pigmentation/Scarring	☐	☐	
Any History of Skin Cancer?	☐	☐	
Do you Wear Sunblock?	☐	☐	
After Sun Exposure, Do you (Check):	☐ Burn	☐ Sometimes Burn	☐ Rarely Burn ☐ Never Burn ☐ Tan
Cellulite	☐	☐	
Questions on Aesthetic Services: Botox, Juvederm or Lasers?	☐	☐	
Interest in Skin Care Consultation?	☐	☐	
Emotional:	**No**	**Yes**	
Do you See Counselor or Psychiatrist?	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
Stress	☐	☐	
Please List any other Complaints			Please List Doctors Seen, Sescribe Condition and How Long
1)			
2)			
3)			

FEMALE Patients

Symptoms	Severity	Date Started	Frequency	Describe
Loss of energy/fatigue				
Loss of sex drive/orgasm				
Fat gain				
Muscle weakness/loss				
Difficulty Sleeping				
Anxiety/Nervousness				
Irritability				
Depression/Emotional Swings				
Decline in Memory				
Decline in Concentration				
Hot Flashes				
Night Sweats				
Vaginal Dryness				

FEMALE Patients

Symptoms	Severity	Date Started	Frequency	Describe
Vaginal Dryness				
Urine Leakage				
Dry Skin/Wrinkles				
Dry Hair				
Hair Loss				
Muscle and Joint Paint				
Loss of Pubic Hair				
Food Cravings				
Sugar Cravings				
Salt Cravings				
List any other Symptoms				
1)				
2)				
3)				

MALE Patients

Symptoms	Severity	Date Started	Frequency	Describe
Loss of Energy/Fatigue				
Loss of Motivation				
Loss of Confidence				
Loss of Sex Drive/Orgasm				
Difficulty Maintaining Erection				
Difficulty Achieving Erection				
Premature Ejaculation				
Fat Gain				
Muscle Weakness/Loss				
Difficulty Sleeping				
Anxiety/Nervousness				
Irritability				
Depression/Emotional Swing				
Decline in Memory				
Decline in Concentration				
Urine Leakage				
Dry Skin/Wrinkles				
Dry Hari				
Hair Loss				
Muscle and Joint Pain				
Loss of Pubic Hair				
Food Cravings				
Sugar Cravings				
Salt Cravings				
List any other Symptoms				
1)				
2)				
3)				

Your signature below attests that you have been truthful and have completed this health questionnaire to the best of your ability.

Signature: _____

Print Name: _____

Date: _____

Millennium Health Centers
Medicine for the 21st Century

Traumatic Brain Injury - Neurosteroid Deficiency Syndrome

A developing area in Hormone Replacement Strategies is the relationship between any form of head trauma and hormone deficiencies. Therefore, please answer the following:

Name **Date of exam**

Please check off any of these activities that you participated in or experienced.

√	Activities	YRS	√	Activities	YRS	√	Activities	YRS
	Boxing			Break dancing			Soccer	
	Wrestling /Grappling			Extreme Sports			Rugby	
	Track and Field			Water or Snow Skiing			Basketball	
	Gymnastics			Skate boarding			Football	
	Martial Arts/MMA			Dirt Bikes / Motocross			Baseball	
	Snow Boarding			Stock Car Racing			Roller Coasters	
	Automobile Accident			Motorcycle Accident			Bicycle Accident	
	Slip and Fall			Explosion (IED)			Repetitive gun fire	
	Pneumatic Tools			Parachutist			Artillary	

Injures related to any of the above activities. LOC means Loss Of Consciousness

Type of Injury	Age	Year	LOC	Hom	ER	Hos	Duration/Comment	GCS

Relative to the head injures above have you experience any of the following?

√	Symptoms	Intensity	√	Symptoms	Intensity
☐	Decrease in Recent Memory	1 2 3 4 5	☐	Lack of Interest in life/Bored	1 2 3 4 5
☐	Decrease in Remote Memory	1 2 3 4 5	☐	Lack of sex drive (libido)	1 2 3 4 5
☐	Lack of Concentration (focus)	1 2 3 4 5	☐	Lack of competitiveness	1 2 3 4 5
☐	Periods of Disorientation	1 2 3 4 5	☐	Lack of confidence	1 2 3 4 5
☐	Mood swings	1 2 3 4 5	☐	Sleeping more (hypersomnia)	1 2 3 4 5
☐	Sudden out-bursts of Anger	1 2 3 4 5	☐	On-set of Insomnia.	1 2 3 4 5
☐	Sudden Irritability	1 2 3 4 5	☐	Change in Sense of Smell	1 2 3 4 5
☐	Depression	1 2 3 4 5	☐	Change in Vision	1 2 3 4 5
☐	Self Isolation	1 2 3 4 5	☐	Anxiety (panic attacks)	1 2 3 4 5
☐	Recurrent Headaches/Migraines	1 2 3 4 5	☐	Change in Menses (Periods)	1 2 3 4 5
☐	Decrease in intelligence	1 2 3 4 5	☐	Increase in Tiredness or fatigued	1 2 3 4 5

Please fill this form out with the physician.

T:_____ LOC:_____ Hosp:_____

Millennium Health Centers
Medicine for the 21st Century

TBI Specific Event Reporting Form

Name Today's Date

*Please fill out one of these **TBI Reporting Forms** for up to 3 of the most significant traumas that you sustained.*

This event happened in (year) _____, as a ☐Civilian, ☐ Soldier, ☐Law Enforcement, ☐Other_____, when I was _____ years old:

	Car Accident (MVA)		Blast Trauma		Gun Fire		Slip n Fall		Stroke		Assault
	Motorcycle (MCA)		IED		Sports (any)		Cannon Noise		Jet engines		Shot Gun
	Bicycle (BCA)		Fall from object		Contact Sport		Martial Arts		Parachute		Surgery
	Football		Rugby		Soccer		Lacrosse		Jujitsu		MMA
	Wrestling		Grappling								

1. With this injury I ☐Did NOT ☐DID have loss of consciousness lasting ____ seconds/minutes/hours/days/weeks.
2. With this injury I ☐Was NOT ☐Was in a Coma for ____hours/days/Weeks/months.
3. With this injury I ☐Did NOT ☐DID have loss of memory immediately before or after the incident.
4. With this injury I ☐Did NOT ☐DID have altered mental state at the time of the incident.
5. With this injury I ☐Did NOT ☐DID have post-traumatic amnesia lasting **LESS**(<) than 24 hours.
6. With this injury I ☐Did NOT ☐DID have post-traumatic amnesia lasting **MORE**(>) than 24 hours.
7. I was taken to: ☐Home ☐Medical Clinic ☐ER ☐Hospitalized for ____hours/days/weeks. Glasgow Scale ____
8. Radiologic Procedures: ☐CT-Scan ☐MRI ☐fMRI ☐SPECT ☐PET Scan ☐DTI-MRI
9. **These are my present symptoms**: (any adverse changes) :

☐ Angry	☐ Anger bouts	☐ Irritable	☐ Short temper	☐ Intolerant	☐ Aggressive
☐ Impatient	☐ Tense	☐ Excitable	☐ Hostile	☐ Defensive	☐ Demanding
☐ Mood swings	☐ Depression	☐ Sad	☐ Grumpy	☐ Mean/hateful	☐ Withdrawn
☐ Memory loss	☐ Anxiety	☐ Nausea	☐ Insomnia	☐ Lonely	☐ Worrying
☐ Sleepy	☐ Bored	☐ Apathetic	☐ Unloved	☐ Muscle pain	☐ Body pain
☐ Disoriented	☐ Dizziness	☐ I'm spinning	☐ world spinning	☐ Headaches	☐ Stomach pain
☐ Paranoid	☐ Alcohol use	☐ Drug use	☐ Narcotics	☐ Marijuana	☐ Low libido

Physician's Notes:

Millennium Health Centers
Medicine for the 21st Century

TBI Specific Event Reporting Form

Name Today's Date

*Please fill out one of these **TBI Reporting Forms** for up to 3 of the most significant traumas that you sustained.*

This event happened in (year) _____, as a ☐Civilian, ☐ Soldier, ☐Law Enforcement, ☐Other_____, when I was _____ years old:

	Car Accident (MVA)		Blast Trauma		Gun Fire		Slip n Fall		Stroke		Assault
	Motorcycle (MCA)		IED		Sports (any)		Cannon Noise		Jet engines		Shot Gun
	Bicycle (BCA)		Fall from object		Contact Sport		Martial Arts		Parachute		Surgery
	Football		Rugby		Soccer		Lacrosse		Jujitsu		MMA
	Wrestling		Grappling								

1. With this injury I ☐Did NOT ☐DID have loss of consciousness lasting ____ seconds/minutes/hours/days/weeks.
2. With this injury I ☐Was NOT ☐Was in a Coma for ____hours/days/Weeks/months.
3. With this injury I ☐Did NOT ☐DID have loss of memory immediately before or after the incident.
4. With this injury I ☐Did NOT ☐DID have altered mental state at the time of the incident.
5. With this injury I ☐Did NOT ☐DID have post-traumatic amnesia lasting **LESS**(<) than 24 hours.
6. With this injury I ☐Did NOT ☐DID have post-traumatic amnesia lasting **MORE**(>) than 24 hours.
7. I was taken to: ☐Home ☐Medical Clinic ☐ER ☐Hospitalized for ____hours/days/weeks. Glasgow Scale ____
8. Radiologic Procedures: ☐CT-Scan ☐MRI ☐fMRI ☐SPECT ☐PET Scan ☐DTI-MRI
9. **These are my present symptoms**: (any adverse changes) :

☐ Angry	☐ Anger bouts	☐ Irritable	☐ Short temper	☐ Intolerant	☐ Aggressive
☐ Impatient	☐ Tense	☐ Excitable	☐ Hostile	☐ Defensive	☐ Demanding
☐ Mood swings	☐ Depression	☐ Sad	☐ Grumpy	☐ Mean/hateful	☐ Withdrawn
☐ Memory loss	☐ Anxiety	☐ Nausea	☐ Insomnia	☐ Lonely	☐ Worrying
☐ Sleepy	☐ Bored	☐ Apathetic	☐ Unloved	☐ Muscle pain	☐ Body pain
☐ Disoriented	☐ Dizziness	☐ I'm spinning	☐ world spinning	☐ Headaches	☐ Stomach pain
☐ Paranoid	☐ Alcohol use	☐ Drug use	☐ Narcotics	☐ Marijuana	☐ Low libido

Physician's Notes:

Millennium TBI Network

Rebuilding Hope one day at a time

Guarantee of Results

Medical Care for Symptomatic TBI

I, _____, have had the opportunity to discuss the potential benefits and risks of a treatment protocol using hormone replacement and a selective supplementation protocol with my physician: [x] Dr. Angelo Baccellieri

It is my clear understanding that there are no guarantees as to the ultimate outcome and benefits that I personally will glean from returning my hormones to a more physiological level, improving upon my dietary nutrition, and by performing an appropriate exercise program.

I understand that results are absolutely individualize and vary from person to person and that my chances of having the results that I am looking for (Patient Goals form) will be based upon the following:

1. Adhering to the nutritional supplementation, dietary recommendations, and hormonal replacement strategies as directed by the physician;
2. Following the timing of the recommended office visits with laboratory testing;
3. Using each and every product, in the timing and quantity as directed by the physician.

Each of these parameters has been reviewed with my physicians and an appointment schedule has/will been/be provided in my Patient's Handbook.

It is my full understanding that the chances of obtaining the outcome that I am looking for is greatest when I follow these recommendations although; I was never given a guaranteed.

I have read this statement and understand and accept the potentiality that I will not have the results that I am looking to obtain*.

Printed Name Signature Date

Millennium TBI Network

Rebuilding Hope one day at a time

Notice of HIPAA Guidelines.

In general, the HIPPA privacy rule is intended to give further protection for the patient's privacy of medical records and information. This federal rule is now a law as of April 14, 2003. It restricts the dissemination of your personal information to any entity other than those that you specifically indicate by an **in-person information release form**. Additionally, we are restricted in the means by which your own information is provided to YOU. Therefore, please indicate by checking all the applicable, those means by which we can continue to provide you with your periodical medical reports:

I wish to be contacted in the following manner(s):
(Check off all that apply)

√	Home Phone:	√	Mobile Phone:
☐	Leave message with detailed information here.	☐	Leave message with detailed information here.
☐	Leave message with callback number only.	☐	Leave message with callback number only.
	Email Report	☐	Written Communications
☐	Leave message with detailed information here.	☐	Please continue to send to my home
☐	Send all reports by email when they are available.	☐	
	I also authorize you to be able to speak with my physicians or family member listed here:		
☐		☐	
☐		☐	
		☐	

Patient's Signature and Date

Printed Name and Date of Birth

Millennium TBI Network

Rebuilding Hope one day at a time

Consent to Medical Care and Treatment

NOTE TO PATIENT: There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned treatment. You have received over one hour of specific education regarding the proposed hormonal treatment based upon your assessment. We have reviewed benefits and risks. You have had an opportunity to ask questions and to request additional information.

I authorize _____Angelo Baccellieri**, M.D.** and such physicians, associates, assistants and other personnel of the Millennium Health Group chosen by him or her to perform the following**:**
Hormonal Assessment and Treatment, and/or to do any other procedure that in their judgment may be advisable to my well-being, including such procedures as are considered medically advisable to obtain the maximal benefits with the least risks in regards to the above proposed program of hormonal replacement therapy.

[___] GENERAL RISKS AND COMPLICATIONS: I am satisfied with my understanding of the more common risks and complications of the treatment, which have been described and I have discussed with the doctor.

[___] SPECIFIC RISKS AND COMPLICATIONS: I am satisfied with my understanding of specific risks of this treatment protocol/program as described by the doctor which included: Risks of breast and prostate cancer in association with the use of Testosterone, Estrogens and Growth Hormone. Weight gain, increased muscular mass, decreased body fat, hair growth, change in hair color, hypoglycemia, disclosure of latent diabetes, transient fluid retention, carpal tunnel syndrome, transient joint pain, headaches, and death.

[___] ALTERNATIVE TREATMENT: I am satisfied with my understanding of alternative treatments and their possible benefits and risks including: **Testosterone Injections, Oral Estrogen/Progesterone replacement, Topical Testosterone, Estrogen, Progesterone replacement or sublingual Testosterone replacement, Isoflavones, Vitamin and mineral replacement.**

[___] NO TREATMENT: I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered.

[___] SECOND OPINION: I have been offered the opportunity to seek a second opinion concerning the proposed treatment from another physician with credentials from the A4M or any physician of my choosing.

[___] LIMITATION OF MEDICAL CARE: I understand that the Millennium Health Groups' doctor (MHG doctor) is providing a specific hormonal treatment and protocol and that he/she is not taking responsibility for any other aspect of my ongoing medical health. **My personal physician shall continue to provide all of my standard and continuous medical care. I hereby authorize the doctor to speak directly with my Primary Care physician when medically necessary regarding my past and present medical care and treatment.**

OTHER QUESTIONS: I am satisfied with my understanding of the nature of the treatment and all of my additional questions about the treatment have been answered.

Signature:_____Date:_____Time_____AM/PM

Primary Physician:_____Telephone#:_____

Millennium TBI Network

Rebuilding Hope one day at a time

Medical Services Agreement (MediCare)

_____(PATIENT) and Angelo Baccellieri (PHYSICIAN) hereby enter into this agreement for provision of medical services specified herein ("Services"). Wherefore, in exchange for consideration, the receipt and sufficiency of which the parties hereby acknowledge, the, PATIENT and PHYSICIAN agree as follows:

1. The PATIENT acknowledges and agrees that this agreement has been entered into before the PHYSICIAN has provided the services specified herein to the PATIENT.

2. The Millennium Health Group and its PHYSICIANS are only responsible for the evaluation and prescription of hormone replacement therapy when indicated by appropriate laboratory testing. All laboratory tests can be billed separately by the laboratory performing those services or else the patient May request to pay a discounted fee.

3. The PATIENT acknowledges and agrees that this agreement has not been entered into at a time when the PATIENT is facing an emergency or an urgent health care situation.

4. The services to be provided to the PATIENT consist of performing diagnostic tests and providing assessment of their chemical and hormonal status. All laboratory tests have an interpretation fee and report fee added to their cost.

5. **[ ]* The PATIENT agrees not to request that a health insurance claim form be submitted in their behalf under the Social Security Act (MEDICARE) for the services, even if such services are otherwise covered under health insurance or MEDICARE.**

6. **The PATIENT agrees to be responsible for the SERVICES.** Although hormone replacement therapy is medically beneficial, insurance companies have not yet accepted this position. At this point in time, neither insurance companies nor MEDICARE will reimburse for preventive care or anti-aging/hormone-balancing replacement therapy. As a result of this, medical records will not be provided to any insurance company or MEDICARE. The United States Department of Health and Human Services, Office of Inspector General take the position that a PHYSICIAN who orders "medically unnecessary" tests may be subject to civil penalties. Because of this, it is the policy of this office not to fill out any insurance benefit claim forms or provide a letter of medical necessity. The Health Insurance and Reform Act of 1997 allows the Federal Government to investigate what they may determine is "health insurance fraud" or any medical treatment not deemed "medically necessary" by the Federal Government. Even though the use of human growth hormone in adults has been approved by the Food and Drug Administration, it has not been recognized by the Federal Government as "medically necessary" and therefore, could, be interpreted as fraudulent.

7. The PATIENT acknowledges that health insurance companies or "Medigap plans" (42 U.S.C., section 1882) will not provided reimbursement, for the SERVICES and that no fee limits (including those specified in 42 U.S.C., Section 1395a-1848g) **will** apply to the amounts PHYSICIANS charge for their SERVICES.

8. The PATIENT acknowledges that PATIENT has the right to have services provided by other PHYSICIANS for whom payment may be made under health insurance plans or MEDICARE.

9. **[ ]* By signing this agreement, the PATIENT understands that they are foregoing their rights to receive insurance/MEDICARE benefits for the SERVICES, but that PATIENT is not forfeiting all health insurance benefits for other services from other health insurance/MEDICARE providers.**

Patient's Signature Date: _____

Physician Signature Date: _____

Witness Signature Date: _____

***** An additional MediCare Contract will be needed for any person who is receiving any financial assistance from MediCare or is of age to receive benefits from MediCare.**

Millennium TBI Network

Rebuilding Hope one day at a time

Private Contract (MediCare Only)

This agreement is between _____Angelo Baccellieri whose principal place of business is _____, and:

Beneficiary: _____

Who resides at: _____

Medicare ID #: _____

and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Beneficiary or his/her legal representative that Physician has opted out of the Medicare program effective on August 1, 2001 for a period of at least two years, to expire on July 31, 2003. The physician is not excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following:

Initial

_____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

_____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

_____ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare.

_____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

_____ Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

_____ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

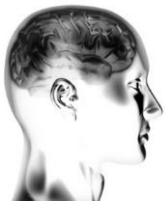
_____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

_____ Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available to him.

Executed on:_____

By(patient): _____ And _____Angelo Baccellieri

Beneficiary or his/her legal representative M.D.



Millennium TBI Network

Rebuilding Hope one day at a time

Reimbursement of Testimony and Subpoena Costs

After reviewing literature on your services involving the diagnosis and treatment of hormone related dysfunction, secondary to neurotrauma, I would like to be evaluated to determine if I am suffering from symptoms caused by a previous or recent injury. You have informed me that you will not agree to accept my case unless I agree to reimburse you for certain expenses that may result from participation in the evaluation of my case; (i.e. personal injury, social security claim, disability claim, insurance claim, etc.).

This document acknowledges that you are not being retained as an expert witness or will be used as one, but that your services for me are as a physician and care giver.

I understand that the evaluation of my case and myself may cause you to be called upon either voluntarily or by subpoena to testify or provide evidence regarding your evaluation (reports, copies of medical records, etc.). I understand that in so doing, you will expend time and incur costs in preparing to give testimony, giving testimony, preparing and producing documentation and possibly retaining counsel to assist you. Therefore I agree as follows:

1. I agree not to designate you as an expert witness in my medical case.
2. I agree that if you are required to either voluntarily or by subpoena to testify or provide evidence regarding your evaluation I shall compensate you with the following amounts which shall be in addition to your standard fees in your capacity as my consulting physician:
    a. $500 per hour for any time spent in consulting with you or counsel;
    b. $5,000/day for any deposition or testimony I am required to provide in your case regardless of whether I am testifying voluntarily or subject to subpoena.
    c. Reimbursement for Business Class travel, hotel accommodations and food.
3. All payments and travel arrangements shall me paid and arranged in advance.
4. I shall reimburse you reasonable attorneys' fees if you determine it necessary to retain your own counsel to represent you.

By signing below I agree to the above referenced terms.

Name: _____

Signature: _____ Date: _____

If you are actively involved in a legal proceeding, please have your attorney review this document and provide the following information:

_____

Attorney name, signature, contact phone number or email

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name:			Date of Birth:	Medical Record:
Patient Address:	City:	State:	Zip:	Date Consent Discussed:

Physician Name:	Location:
Consultant Name:	Location:
Consultant Name:	Location:

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error;

Please initial after reading this page: _____

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. _____ (*name of Physician*) has explained the alternatives to my satisfaction,
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform _____ (*name of Physician*) of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I attest that I am located in the state of California and will be present in the state of California during all telehealth encounters with _____ (*name of Physician*).

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize_____ (*name of Physician*) to use telemedicine in the course of my diagnosis and treatment.

_____ _____

PATIENT'S SIGNATURE **DATE**
(OR AUTHORIZED PERSON TO SIGN FOR PATIENT)

_____

IF AUTHORIZED SIGNER, RELATIONSHIP TO PATIENT

_____ _____

WITNESS **DATE**

_____ _____

PHYSICIAN'S SIGNATURE **DATE**

I have been offered a copy of this consent form. _____ (Patient's Initials)