MARKOU MEDICAL

Welcome to Markou Medical! Always here, always available! Thank you for trusting us with your health care! This welcome packet includes your new patient paperwork to fill out and bring with you to your first visit as other information about our providers, locations, and services.

We will provide you with same-day office visits for any acute needs during normal office hours and provide one of our own highly trained providers on call 24/7 to meet any acute needs that might come up.

I am excited for the opportunity for us to meet you and to help meet your healthcare needs!

Respectfully,

Michael Markou, DO, FACOFP

Clearwater
1266 Turner St. Suite A
Clearwater, FL 33756
Phone 727-446-0176
MarkouMedical.com

Tarpon Springs
1779 S. Pinellas Ave. Suite 300
Tarpon Springs, FL 34689
Phone 727-940-2099
MarkouMedical.com

MARKOU MEDICAL

Welcome To Our Practice!

Please keep this form so that you have access to this information when needed.

Our physicians are available 24 hours a day, after hours, for your urgent healthcare needs. Upon contacting our office after hours, one of our providers will personally return your call. Avoid expensive emergency room co-pays, long wait times, and physicians who are not familiar with your specific healthcare history.

- **Urgent Needs:** Always call us with urgent health concerns—even after hours—so we can assist you over the phone or schedule an appointment as needed.
- **Preferred Hospitals:** Morton Plant or other BayCare facilities due to trusted relationships with their staff and specialists.
- **Preferred Lab:** Quest Diagnostics.
- **Post-Hospital/ER Care:** Contact us immediately after discharge. A follow-up appointment is required within 24–48 hours to support your recovery.
- **Medicare Patients:** Your provider encourages you to be seen at least every six months to maximize preventive care.
- **Appointments:** Call to schedule and **bring a current list of medications** or bottles of medications to appointments. Please cancel at least 24 hours in advance if needed.
- **Referrals:** To avoid unexpected bills, call us before seeing a specialist or having any tests or procedures, as Humana requires prior authorization. **DO NOT** go for lab tests, x-rays, physical therapy, etc. until our office is notified.

MARKOU MEDICAL

New Patient Information

Welcome to Markou Medical. If you need any assistance, please let the receptionist know.

Patient_____

Last Name First Name Middle initial

SS#_____Birth date_____

Home Phone #_____Cell #_____

E-mail:_____

Street Address_____

City_____State_____Zip_____

Sex M F Age_____ Significant Other Name: _____

Emergency Contact: _____

Name(s) Phone #

Do you have any specialist appointments scheduled? Yes No

- Where & When _____

Prior Doctor and Phone Number: _____

How did you find out about us?

- Friend or relative Name: _____
- Insurance agent Name: _____
- Newspaper/Newsletter
- Social Media
- Google
- Humana.com or Medicare.gov
- Other _____

MARKOU MEDICAL

MEDICATION LIST / ALLERGIES / PHARMACY

Please help us provide better care by providing us with your current prescription and over-the-counter medications taken regularly.

PRESCRIPTIONS:

Medication Name	Dosage	Times Daily	When Started?

OVER-THE-COUNTER MEDICATIONS / HERBAL REMEDIES / VITAMINS:

_____ _____

_____ _____

_____ _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ **Yes** ☐ **No**

If yes, please list medication and the reaction.

MEDICATION ALLERGIES & REACTIONS:

Medication Name	Reaction

PHARMACY INFORMATION (Required):

Pharmacy Name: _____

Pharmacy Address or Cross Streets: _____

Pharmacy Phone: _____

MARKOU MEDICAL

FAMILY HISTORY

FAMILY MEMBER	CIRCLE SEX	IF LIVING		IF DECEASED	
		AGE	HEALTH	AGE AT DEATH	CAUSE
Father					
Mother					
Brother(s) / Sister(s)	M F				
	M F				
	M F				
Husband / Wife					
Son(s) / Daughter(s)	M F				
	M F				
	M F				
	M F				

Check if any blood relative has or had any of the following and enter their relationship to you:

	Yes	No	Relationship to you	Comments
Bleeding Tendency	☐	☐		
Cancer	☐	☐		
Colitis	☐	☐		
COPD	☐	☐		
Diabetes	☐	☐		
Epilepsy	☐	☐		
Heart Attack	☐	☐		
High Blood Pressure	☐	☐		
Kidney Disease	☐	☐		
Sickle Cell Anemia	☐	☐		
Stroke	☐	☐		
Suicide	☐	☐		
Tuberculosis	☐	☐		
Other:	☐	☐		

MARKOU MEDICAL

Patient Last Name: _____ **Patient First Name:** _____ **DOB:** _____

Choose One: [ ] Male [ ] Female

Past Medical History: Have you ever had one of the follow illnesses?

	Yes	No		Yes	No		Yes	No
Amputation	☐	☐	Diabetes	☐	☐	Migraine Headache	☐	☐
Anemia	☐	☐	Falls	☐	☐	Ostomy	☐	☐
Alcohol Overuse	☐	☐	Gout	☐	☐	Paralysis	☐	☐
Arthritis	☐	☐	HIV/AIDS	☐	☐	Sexually	☐	☐
Asthma	☐	☐	Heart Attack	☐	☐	Transmitted Disease		
Bleeding Disorders	☐	☐	Heart Disease	☐	☐	Sickle Cell Anemia	☐	☐
Cancer	☐	☐	(CHF/CAD)			Sleep Disorder	☐	☐
Location: _____			Hepatitis	☐	☐	Stomach Ulcer	☐	☐
Cardiac Arrhymias	☐	☐	High Blood Pressure	☐	☐	Stroke, CVA/TIA	☐	☐
Pacemaker: _____			Kidney Disease	☐	☐	Thyroid Disease	☐	☐
Colitis	☐	☐	Mental Illness	☐	☐	Vascular Disease	☐	☐
COPD/Emphysema	☐	☐	Other Medical History: ___					

Symptoms you would like to discuss: _____

Personal Habits: Have you ever?

Smoked tobacco? ☐ Yes ☐ No If yes, packs per day____#of years_____ Year quit _____

Used chewing tobacco? ☐ Yes ☐ No If yes, # of cans_____# of years_____Year quit_____

Do you drink alcohol regularly? ☐ Yes ☐ No If yes, how often_____# of drinks per day_____

Have you ever used? ☐ Marijuana ☐ LSD ☐ Heroin ☐ Cocaine ☐ Meth ☐ Other

Operations: List with approximate year

_____ _____

_____ _____

_____ _____

_____ _____

Serious Injuries: List with approximate year

_____ _____

_____ _____

_____ _____

_____ _____

Hospitalization (Other than operations with approximate date):_____

_____

Immunizations (please include the date):		Covid-19 _____	Prevnar 13 _____
Tetanus _____	Shingles _____	Flu _____	Prevnar 20 _____
Other _____	MMR _____	Hep _____	Pneumovax 23 _____

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Preventative Service History

This form needs to be completed to the best of your ability.

We need to know if the below listed testing has: Never Been Done (NO), Has Been Done (YES). If yes, your best estimate as to the month/year the test was performed, and the result.

Preventative Service	NO	YES	Month/Year Testing Performed	Findings & Recommendations
Bone Mass Measurement (Bone Density)	☐	☐		
Bloodwork	☐	☐		
Colorectal Cancer Screening Colonoscopy –	☐	☐		
Fecal Occult Blood Test (Stool Card)	☐	☐		
Vision Screening Eye Exam	☐	☐		
Female Screening PAP & Pelvic Examination	☐	☐		
Mammogram	☐	☐		
Male Screening PSA – Prostate Specific Antigen (Blood Test)	☐	☐		

FOR PHYSICIAN USE

Physician Signature

Date Reviewed

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SOCIAL / LIFESTYLE HISTORY:

Primary Language: _____

Interpreter Required: ☐ Yes ☐ No

Is there someone that lives with you in your residence? ☐ Yes ☐ No

If yes, please list name & relationship: _____

Type of Residence: ☐ Apartment ☐ Mobile Home ☐ House ☐ One Story ☐ Two Story

☐ Independent Living Facility Facility Name: _____

☐ Assisted Living Facility Facility Name: _____

Durable Medical Equipment? ☐ Yes ☐ No ☐ Wheelchair ☐ Walker ☐ Cane

☐ Oxygen ☐ Nebulizer ☐ CPAP/BIPAP

Other: _____

Can you afford medicine? ☐ Yes ☐ No Potential Referral to Patient Assistance Program: _____

Transportation provided by? _____

EXERCISE / ACTIVITY:

Current Activity: _____ How Often: _____

Physical Limitations: _____

ACTIVITIES OF DAILY LIVING:

Do you require assistance to bathe or groom? ☐ Yes ☐ No

If yes, explain: _____

Do you require assistance for your toilet needs? ☐ Yes ☐ No

If yes, explain: _____

Do you require assistance to eat? ☐ Yes ☐ No

If yes, explain: _____

Do you have hearing loss? ☐ Yes ☐ No

Do you wear hearing aids? ☐ Yes ☐ No

Date of last hearing exam: _____

Additional Comments & Notes: _____

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REVIEW OF SYSTEMS

Constitutional

- ☐ Fever
- ☐ Chills
- ☐ Feeling Poorly
- ☐ Feeling Tired
- ☐ Recent Weight Gain _____ lbs.
- ☐ Recent Weight Loss _____ lbs.

Eyes

- ☐ Blurry Vision
- ☐ Glaucoma
- ☐ Eye Infection
- ☐ Dry Eyes
- ☐ Red Eyes

ENT

- ☐ Ringing in the Ears
- ☐ Throat Clearing
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Mouth Sores

Cardiovascular

- ☐ Heart Rate Slow
- ☐ Heart Rate Fast
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Lower extremity Edema

Respiratory

- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Cough
- ☐ Shortness of Breath on Exertion
- ☐ Spitting up Blood

Genitourinary

- ☐ Dysuria
- ☐ Incontinence
- ☐ Testicular Pain
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Abnormal Vaginal Bleeding
- ☐ Genital Lesion

Heme/Lymph

- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Swollen Glands

Musculoskeletal

- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Joint Stiffness

Integumentary

- ☐ Skin Rash
- ☐ Skin Wound
- ☐ Itching
- ☐ Jaundice

Neurological

- ☐ Confusion
- ☐ Numbness
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache

Psychiatric

- ☐ Suicidal
- ☐ Depression
- ☐ Anxiety
- ☐ Sleep Disturbances

Endocrine

- ☐ Heat Intolerance
- ☐ Excessive Thirst
- ☐ Cold Tolerance
- ☐ Excessive Urination

Gastrointestinal

- ☐ Poor Appetite
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Diarrhea
- ☐ Rectal Bleeding
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloating
- ☐ Abdominal Pain
- ☐ Black Tarry Stools
- ☐ Belching
- ☐ Regurgitation
- ☐ Constipation
- ☐ Recent change in Bowel Habits

MARKOU MEDICAL

ANNUAL PATIENT ASSESSMENT

Patient label:

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (circle the number to indicate your answer)	**Not At All**	**Several Days**	**More than Half the Days**	**Nearly Every Day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, or that you are a failure or have let yourself or family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Add Columns ☐ + ☐ + ☐

TOTAL ☐

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐ Not difficult at all	☐ Very difficult
	☐ Somewhat difficult	☐ Extremely difficult

Bladder and Additional Screening

- Are you having any bladder control problems? ☐ Yes ☐ No
  - *If "yes", please answer the remaining questions. This information will help your practitioner better understand your bladder control problem.
  - I started having bladder trouble: ☐ A Month(s) ago ☐ 1 to 2 years ago ☐ ___ years ago
- Do you require assistance to walk? ☐ Yes ☐ No
- Do you have any problems with your hearing, vision or speech?
  - Hearing: ☐ Yes ☐ No Vision: ☐ Yes ☐ No Speech: ☐ Yes ☐ No

Social Determinants of Health Screening

1. **What is your living situation today?**
   - ☐ I have a place to live today, but I am worried about losing it in the future
   - ☐ I do not have a steady place to live now or in the past 12 months
   - ☐ I have a steady place to live

2. **Within the past 12 months, have you not had enough food or worried that your food would run out before you have money to buy more?**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

3. **In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?**
   - ☐ Yes
   - ☐ No

4. **In the past 12 months, have you had issues paying for your electricity, gas, oil, water, or any other basic needs?**
   - ☐ Yes
   - ☐ No

5. **Are you currently employed?**
   - ☐ No (looking for work)
   - ☐ Yes
   - ☐ N/A (retired, disabled)

6. **Do you feel like your insurance or welfare support is not enough and that you could benefit from an increase in benefits/support?**
   - ☐ Yes
   - ☐ No

7. **How hard is it for you to pay for the very basics like food, housing, medical care, and heating?**
   - ☐ Very
   - ☐ Somewhat
   - ☐ Not at all

8. **How often so you feel lonely, excluded or isolated from family, friends or your community?**
   - ☐ Always
   - ☐ Sometimes
   - ☐ Never
   - ☐ Often
   - ☐ Rarely

9. **If you live alone, do you have issues with mobility, cooking, cleaning or worrying about safety issues?**
   - ☐ Yes
   - ☐ No
   - ☐ I do not live alone

10. **Have you been a victim of war or persecution, or have you been displaced from your home?**
    - ☐ Yes
    - ☐ No

Patient Name Printed	Patient Name Signed	Date

MARKOU MEDICAL

Notice of Privacy Practices

At Markou Medical, we take your privacy seriously. We follow all laws to protect your personal health information (PHI) and only use it to give you the best care, handle billing, and run our office.

Here's what you can expect from us:

- We follow the rules in our **Notice of Privacy Practices**.
- We only use or share your health information as allowed by law—for treatment, payment, and care operations—not for marketing or other outside use unless you give permission.
- We may send appointment reminders unless you ask us not to.
- We work hard to keep your information accurate, secure, and up to date.
- We respect your dignity and privacy at all times.
- You have the right to:
    - View or get a copy of your medical records (a fee may apply)
    - Ask us to fix any incorrect or incomplete information in your record
    - Ask for a list of who we've shared your information with, outside of normal care and billing
    - Appeal if your request to see your record is denied—another provider will review it

All of our providers and staff must follow this policy. Anyone who doesn't may face disciplinary action.

We may update this policy in the future, and you can always request a copy.

Receipt of Notice of Privacy Practices Written Acknowledgement

By signing, I affirm that I received a copy of Markou Medical's Privacy Policy.

Patient Signature:_____ Date: _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative: _____

MARKOU MEDICAL

HIPPA Release of Information

Patient authorization for use/disclosure of protected health information (PHI) for purposes requested by the practice.

"Only as permitted or required by Federal or State Law", we may use your PHI to do the following:

- To disclose, as may be necessary, your health information (including HIV/AIDs status, drug/alcohol abuse/dependency, mental health notes, etc.) to other healthcare entities (such as referrals to or consultation with other health care entities) or to others as may be required by law or court concerning your treatment, payment, or other healthcare.
- To request from other healthcare entities (such as doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care of treatment.
- To submit necessary information to insurance companies for coverage verification as well as the diagnosis and treatment information to your insurance companies, other agencies, and/or individuals for payment of the services/treatment we provide for you.
- To discuss your healthcare payment information (only the minimum necessary in our judgement) with family members or other persons who are or may be involved in your health care treatment or payments.
- To leave appointment reminders or other minimal necessary information related to your health care or health care payments on your answering machine, mobile voicemail or text message, email, or with a household family member.

You may request a copy of, and you have the right to read our notice of patient privacy practices prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

By signing this form, I authorize Markou Medical to release/disclose my medical information, medical history, progress notes with diagnosis, laboratory data, imaging studies, and claims information.

This information may be released to:

☐ Name: _____ Phone: _____

☐ Name: _____ Phone: _____

☐ Name: _____ Phone: _____

☐ This information if NOT to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing. My written revocation must be submitted to Markou Medical. This practice will not receive payment or other remuneration from a third party in exchange for using or disclosing PHI. I do not have to sign this authorization to receive treatment from Markou Medical. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule.

Patient Signature:_____Date: _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative: _____

MARKOU MEDICAL

Authorization for the Release of

I hereby give my permission to (list physician / facility name, address & phone number):

_____ _____

_____ _____

_____ _____

_____ _____

To release a copy of my Protected Health Information (PHI) to: **Markou Medical** I instruct

the above named entity to produce the following information (check ONE only):

☐ Release Entire Record
☐ I would like specific records released: _____

My PHI is to be disclosed for: ☐ Continuation of Care ☐ Other: _____

Please forward records to the following location (Circle One):

1266 Turner St. Suite A
Clearwater, FL 33756
Phone: (727) 446-0176
Fax: (727) 446-4906

OR

1779 S. Pinellas Ave. Suite 300
Tarpon Springs, Fl 34689
Phone: (727) 940-2099
Fax: (727) 446-4906

Unless otherwise noted, this authorization expires one year from date signed.

I authorize Markou Medical or an authorized representative of the patient and requests that the above named facility to release any and all information which the named facility may possess in regard to the patient's examinations and treatments, including, but not limited to, alcohol abuse or drug abuse information, HIV antibody testing information, psychiatric and/or psychological information, communicable disease information, or any other information related to the patient's total treatment, unless specified below which may be a part of the medical records. I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on the Authorization. I am entitled to a copy of this authorization upon request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. This recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the discloser is specifically required by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

Patient Name (Print) :_____ DOB : _____

Patient Signature :_____ Date : _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative: _____

MARKOU MEDICAL

Understanding Your Insurance & the Referral Process

If the insurance plan you have selected is an HMO/managed care plan.

1. Your PCP oversees your overall health to make the best decisions for your care.
2. If you need a specialist, your PCP will coordinate that care within your HMO network.
3. A referral from your PCP is required before seeing any specialist.
4. Your PCP will select a specialist suited to your needs from within the HMO network.
5. HMO networks include select providers known for delivering high-quality care.
6. Unlike PPOs, HMO coverage only applies to in-network providers.
7. Referrals ensure clear communication between your PCP and specialist to help you get the right care.

Yearly Insurance Authorization, Assignment, and Guarantee of Payment

I give permission for Medicare and/or my insurance to send payments directly to Markou Medical for any services I receive.

I also allow Markou Medical to share my medical information with Medicare or my insurance company if needed to process my claims. A copy of this form is valid like the original.

If I receive any insurance checks meant for Markou Medical, I agree to sign them over right away.

I understand I'm responsible for any charges not covered by Medicare or insurance. I confirm the information I've given is correct and agree to this payment arrangement.

A charge of $45 will be billed to your account for any missed appointments. This is <u>not</u> billable to your insurance company.

Patient Signature:_____ Date: _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative: _____

MARKOU MEDICAL

Patient Consent

I give Markou Medical permission to use and share my health information, including HIV/AIDS testing or status, to help with my care, billing, and office operations. This is explained in more detail in their "Notice of Privacy Practices," which I can read at any time. I can also request a copy by writing to: **Markou Medical, Attn: Privacy Officer, 1266 Turner St. Suite A, Clearwater, FL 33756**

With this permission, Markou Medical may:

- Call or leave a voicemail about appointments, insurance, test results, other care-related information
- Mail appointment reminders or billing statements to my home or another address, marked “Personal & Confidential”
- Email appointment reminders or billing statements

I can ask Markou Medical to limit how my information is shared, but they don’t have to agree to the request.

By signing, I agree to let Markou Medical share my information as needed, including with insurance companies. I can cancel this consent in writing at any time, but it won’t affect anything already shared. If I don’t sign or later cancel, they may not be able to treat me.

Patient Signature:_____ Date: _____

Consent for Diagnostic and/or Therapeutic Procedures

I give permission for my doctor and care team to examine me, run routine tests, and provide treatment or medications as needed. I understand any risks will be explained, and I can refuse any test or treatment at any time.

Patient Signature:_____ Date: _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative: _____

MARKOU MEDICAL

Prescription Renewal Policy

Our doctors are available 24/7 for true emergencies. Medication refills are not emergencies and should be handled during regular office hours—Monday to Friday, 8 AM to 5 PM.
Please request refills during your visit or by calling our medical assistants. We'll respond within 24 hours. This helps us provide safe, timely care for everyone.

Patient Conduct and Examination Room Escort Policy

Markou Medical has a zero-tolerance policy for any physical threats, verbal abuse, or disrespect toward our staff or other patients. We reserve the right to end care and dismiss anyone from the practice for such behavior.
If it makes you more comfortable, you may have a friend, family member, or staff member with you during your exam. In some cases, your provider may also request an escort to be present.

Health Maintenance

To help you stay healthy, it is important to us that you, our patient adhere to the following:

- Don't smoke
- Maintain a healthy weight
- Exercise daily (walk, swim, etc.)
- Eat a heart-healthy diet (low in cholesterol, calories, and saturated fats; limit salt)
- Avoid alcohol or drink only in moderation
- Always wear seatbelts and bike helmets
- Avoid all illegal or recreational drug use
- Practice safe sex to prevent HIV and STDs
- Have yearly eye exams
- **Women:** Get mammograms and Pap smears as recommended for your age
- **Men:** Get regular prostate screening based on age guidelines
- **Everyone:** Get regular lab work and colon cancer screening based on age and risk factors

Patient Signature:_____ Date: _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative: _____

Informed Consent and Agreement for Appropriate Behavior in Office and With Staff

The Behavior in Question: _____

Our Commitment to You:
We are committed to providing respectful, high-quality care and working with you as a partner in your health. We will explain your treatment options and respect your choices. In return, we ask for your cooperation and appropriate behavior.

Your Rights:
As a patient, you have the right to accept or refuse treatment. You also have the right to be informed about your treatment options-including the benefits, risks, and any alternatives-so you can make the best decisions for your health. You can change your mind about treatment at any time.

Your Responsibilities:
You are expected to treat all physicians, staff, and fellow patients with respect at all times, both inside and outside the office. This includes:

- No physical or verbal abuse
- No threatening, insulting, or offensive language
- No inappropriate behavior toward others in the office or outside settings

Failure to follow these expectations may result in dismissal from the practice.

Patient Agreement:
I understand that if I do not follow the behavior and conduct expectations outlined in this agreement, Markou Medical has the right to stop providing care to me and formally discharge me from the practice as a "transfer for cause."

I also give Markou Medical permission to share a copy of this agreement with my pharmacy, other healthcare providers, or my insurance company if requested.

Additionally, I agree that my doctor, physician assistant, or any Markou Medical staff may share my medical information with other parties when it's needed for my care or for billing purposes. I also agree to give up certain privacy protections if needed for Markou Medical to fully cooperate with state or federal laws, or with agencies like Medicare or Medicaid (CMS).

By signing, I confirm that I have read and understand this agreement and agree to the above.

Patient Name (Print) :_____ DOB : _____

Patient Signature :_____ Date : _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative: _____

I have discussed the risks, hazards, limitations and benefits, as well as alternative treatment possibilities with the patient and answered all questions asked of me.

Provider Signature :_____ Date : _____

MARKOU MEDICAL

Advance Directive

What is an Advance Directive?

An advance directive is a way to let your family and doctors know what kind of medical care you want if you're too sick or hurt to speak for yourself.

There are two kinds of advance directives:

- **A Living Will:** Says what kind of treatments you want or don't want if you're very sick and not expected to get better—like being on a breathing machine if you're in a coma.

- **Durable Power of Attorney for Health Care:** Lets you pick someone you trust to make medical decisions for you if you can't.

Is one better than the other?

Each one helps in different ways, and many people use both. You can even combine them so your chosen person knows what you would want.

Can I change my mind?

Yes! You can change or cancel your directive anytime—just write it down and sign it, or tell someone your new wishes.

Who should make out an Advance Directive?

Any adult. Accidents and serious illnesses can happen at any age, so it's good to be prepared.