Welcome to our practice!

We appreciate the opportunity to provide you with your skin care needs! Our staff is made up of well-trained and happy professionals, who work together as a team to bring you the highest quality treatment in a warm, caring setting. If you have any questions, please feel free to ask any one on our staff.

The office is open Monday-Friday 8:00am-5:00pm.

We see all patients on an appointment basis and ask that you call in advance so that we may reserve time for you. If you cannot keep an appointment, please notify us immediately, when possible. We ask that you give us at least a 24 hours notice so that the time may be given to another patient.

Please bring updated medication lists and insurance information with you to each visit so that we may keep your medical record up to date and provide you with optimal care.

At the Skin Cancer Institute, we want to be a blessing for those we serve. To care for not only the skin, but to fully care for all who walk through our door. To prevent illness when we are able, to cure whenever possible, and to provide care and support when no cure can be found. We pledge to be more than just a clinic. We pledge to be a companion in your care and to treat each patient as if they were a part of our own family. Again, welcome to our clinic; we look forward to seeing you.

REGISTRATION FORM - Skin Cancer Institute

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: First:	Middle:	Marital status:

Is this your legal name?	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex:
◯ Yes ◯ No					◯ M ◯ F

Address:		Email Address:
		Social Security no.:
Occupation:	Employer:	Employer phone no.:

Preferred Pharmacy:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	◯ Yes ◯ No	Is this patient covered by insurance?	◯ Yes ◯ No
Occupation:	Employer:	Employer address:	Employer phone no.: [Phone]

Is this visit a work related injury or liability case? Yes No

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Skin Cancer Institute or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Skin Cancer Institute

Past Medical History (please mark yes or no)

Anxiety	yes	no
Asthma	yes	no
Atrial Fibrillation	yes	no
Bone Marrow Transplant	yes	no
BPH	yes	no
Breast Cancer	yes	no
Colon Cancer	yes	no
COPD	yes	no
Coronary Artery Disease	yes	no
Depression	yes	no
Diabetes	yes	no
End Stage Renal Disease	yes	no
GERD	yes	no
Hearing Loss	yes	no
Hepatitis	yes	no
Hypertension	yes	no
HIV/AIDS	yes	no
Hypercholesterolemia	yes	no
Hyperthyroidism	yes	no
Leukemia	yes	no
Lung Cancer	yes	no
Lymphoma	yes	no
Prostate Cancer	yes	no
Radiation Treatment	yes	no
Seizures	yes	no
Stroke	yes	no

Other:
____
____
____

Skin Disease History

Acne	yes	no
Actinic Keratosis	yes	no
Basal Cell Skin Cancer	yes	no
Blistering Sunburns	yes	no
Dry skin	yes	no
Eczema	yes	no
Flaking or itchy Scalp	yes	no
Hay fever/allergies	yes	no
Melanoma	yes	no
Poison Ivy	yes	no
Precancerous Moles	yes	no
Psoriasis	yes	no
Squamous cell skin cancer	yes	no

Other:

____

Do you wear sunscreen? Yes no

If yes, what SPF? ________________

Do you tan in a tanning salon? Yes no

Family History

Do you have a family history of melanoma? Yes no

If yes, which family member/relative? ____

Medication List

Please list all medications and dose.

Medication____________________________________strenghth/dose_____________________________

Medication____________________________________streghth/dose_____________________________

Medication____________________________________streghth/dose_____________________________

Medication____________________________________streghth/dose_____________________________

Medication____________________________________streghth/dose_____________________________

Medication____________________________________streghth/dose_____________________________

Medication____________________________________streghth/dose_____________________________

Medication____________________________________streghth/dose_____________________________

Allergies

Do you have any food or drug allergies? Yes no

List allergies and describe reaction.

Allergy_________________________________Reaction____

Allergy_________________________________Reaction____

Allergy_________________________________Reaction____

Allergy_________________________________Reaction____

Allergy_________________________________Reaction____

Social Status

Do you smoke? Yes no

If yes, date you started smoking: ______________________Quit smoking? ______________________________

Number of packs per day? _____________________________ Total Years Smoking? ______________________

Illicit drug use yes no

Alcohol use yes no

If yes, check the appropriate field

Less than 1 drink per day

1-2 drinks per day

3 or more drinks per day

Marital Status

(please initial your status)

Married_________Single_____________Divorced____________Widowed____________

Do you drive? Yes no

If yes, do you drive in the daytime? ___________________Nighttime? _________________

How often do you exercise?

__________Several times a day

__________Once a day

__________A few times a week

__________A few times a month

__________Never

What is your caffeine use?

__________Several times a day

__________Once a day

__________A few times a week

__________A few times a month

__________Never

Please list your Occupation and Workplace. ____

Place of Residence. ____

Past Surgeries

Have you had any surgeries on the following organs?

Please circle all that apply

None

Appendix (Appendectomy)

Bladder (Cystectomy)

Breast: Breast Biopsy

Breast: Lumpectomy (Both Breasts)

Breast: Lumpectomy (Left Breast)

Breast: Lumpectomy (Right Breast)

Breast: Mastectomy (Both Breast)

Breast: Mastectomy (Left Breast)

Breast: Mastectomy (Right Breast)

Colon (Colectomy): Colon Cancer Resection

Colon (Colectomy): Diverticulitis

Colon (Colectomy): Inflammatory Bowel Disease

Colon: Colostomy

Past Surgeries (continued)

Gallbladder (cholecystectomy)

Heart: Biological Valve Replacement

Heart: Coronary Artery Bypass Surgery

Heart: Heart Transplant

Heart: Mechanical Valve Replacement

Heart: PTCA

Joint Replacement: Hip (Both)

Joint Replacement: Hip (Left)

Joint Replacement: Hip (Right)

Joint Replacement: Knee (Both)

Joint Replacement: Knee (Left)

Joint Replacement: Knee (Right)

Kidney: Kidney Biopsy

Kidney: Kidney Stone Removal

Kidney: Kidney Transplant

Kidney: Nephrectomy

Liver: Hepatectomy

Liver: Liver Transplant

Liver: Shunt

Ovaries (Oophorectomy): Endometriosis

Ovaries (Oophorectomy): Ovarian Cancer

Ovaries (Oophorectomy): Ovarian Cyst

Pancreas: Pancreatectomy

Prostate (Prostatectomy): Prostate Biopsy

Prostate (Prostatectomy): Prostate Cancer

Prostate (Prostatectomy): TURP

Rectum: APR

Past Surgeries (continued)

Rectum: Low Anterior Resection

Skin: Melanoma

Skin: Skin Biopsy

Skin: Squamous Cell Carcinoma

Spleen(Splenectomy)

Testicles(Orchiectomy)

Uterus(Hysterectomy): Fibroids

Uterus(Hysterectomy): Uterine Cancer

Uterus(Hysterectomy): Cervical Cancer

Other:

____

____

Skin Cancer Institute
4709 66th street
Lubbock, Texas 79414
(806) 701-5844

Notice of Privacy Practices

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

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 PERSONAL HEALTH INFORMATION.

PLEASE REVIEW NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your personal health information (PHI). 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 are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerni9ng your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time that these laws are complicated, but we must provide you with the following important information:

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

The terms of this notice apply to all records contain your PHI 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 your 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 ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Paige Wallace,4709 66th street, 806-701-5844

C. WE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATIN (PHI) IN THE FOLLOWING WAYS.

1. **Treatment.** The physicians in this practice are specialist. When we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. **Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents.**
2. **Payment.** Our practice any use and disclose your PHI 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 you PHI to obtain payment from third parties that may be responsible for such costs, such as family member. Also, we may use your Phi to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use your information for our operations, our practice may use your PHI to evaluate the quality of care your received from us, or to conduct cost-management and business planning activities for our practice.
4. **Disclosures Required by Law.** Our practice will use and disclose your PHI when we are required to do so by federal state or local law.

D. **Breach of PHI.** We take our role of safeguarding your PHI very seriously, using it in an appropriate manner. When a breach is discovered, you will be noticed and kept abreast of the situation and the steps we are taking to rectify this breach.

E. **USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCE**

1. **Public health risks.** Our practice may disclose your PHI 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 PHI to a health oversight agency for activities authorized by law. Oversight activities can include for example, investigations, audits, surveys, licensure and disciplinary action; 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 PHI 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 protection the information the party has requested.
4. **Law enforcement.** We may use release PHI if asked to do so by law enforcement official:
   - Regarding a crime victim in certain situations. If we are unable to obtain the person agreement
   - Concerning a death w believe has resulted from criminal conduct
   - Regarding criminal conduct at our office
   - 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 victims) or the crime, or the description, identity or location of the perpetrator.
5. **Serious Threats to Health or Safety.** Our practice may use and disclose your PHI 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 circumstance, we will only make disclosures to a person or organization able to prevent the threat.

F. **YOUR RIGHTS REGARDING YOUR PHI** you have the following rights regarding the PHI 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 Privacy Officer, Paige Wallace, 4709 66th street, Lubbock, Texas 79414 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 PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individual 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 PHI, you must make your request in writing to Privacy Officer, Paige Wallace, 4709 66th street, Lubbock, Texas 79414.
   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 to limit to apply
3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about your, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Privacy Officer, Paige Wallace, 4709 66th street, Lubbock, Texas 79414 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice any 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. This will include all electronic records if circumstances apply
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 make in writing and submitted to Privacy Officer, Paige Wallace, 4709 66th street, Lubbock, Texas 79414. 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 your opinion (a) accurate and complete (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy;(d) not created by our practice, unless the individual in entity that created the information is not available to ament the information.
5. **Accounting of disclosures.** All of our patients have the right to request an "accounting of disclosures." And "accounting of disclosures" is a list of certain non-routine disclosures our practice has make of your PHI for non-treatment or operations purposes. Use of your PHI 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 Privacy Officer, Paige Wallace, 4709 66th street, Lubbock, Texas 79414**.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six years' information to file your insurance claim. 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 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 Privacy Officer, Paige Wallace, 4709 66th street, Lubbock, Texas 79414.
7. **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 PHI may be revoked at any time <u>in writing</u>. After you revoke your authorizations, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.