Midland Skin Cancer Center
Russell Akin MD PLLC
Midland TX
432-689-2512 Fax 432-689-2108

Welcome to Russell Akin MD PLLC. Our goal is to provide you with the highest quality of treatment and service.

We appreciate you taking the time to complete these New Patient Forms thoroughly to help us maintain accurate contact and medical records. This information is critical to us in assisting you with the care, treatment and management of your dermatological needs.

There are several pages for you to fill out:

The first is a **PATIENT INFORMATION FORM** requesting patient and insurance information. Your signature and date are required.

Next is a **MEDICAL HEALTH QUESTIONNAIRE**. We must know the details of your current and prior medical condition in order to provide you with quality health care. This form is required to be updated on an annual basis. Your signature and date are required.

Next is a page outlining your **FINANCIAL RESPONSIBILITIES** and your rights concerning privacy of your **PROTECTED HEALTH INFORMATION**. Please read these policies and sign and date in both places.

Another page authorizes persons selected by you to receive information regarding your financial account, appointments, pathology results, treatment and/or other information pertinent to your healthcare. The names of any individuals you wish this information released to, signature and date are required.

If you are on Medicare and/or have a Medigap policy there is an additional page of statements that you must read and sign.

If the patient is a minor there is an additional page for parents/guardians to give permission for Russell Akin MD PLLC to treat the minor child if they arrive to the office unaccompanied.

If you printed these forms from our website, you may fax them to us prior to your appointment, or bring the completed original forms with you to your appointment along with the other items requested below.

If you need assistance completing these forms, our receptionist will be happy to help when you arrive for your appointment.

REMINDERS OF REQUIRED ITEMS
FOR YOUR VISIT

- **Insurance Cards** If you have health insurance, we cannot see you without making a copy of your insurance card.
- **Written Referral** from your Primary Care Physician if required by your insurance plan.
- **Co-pay, Coinsurance** or **Deductible** is collected at the time of visit.
- **Cosmetic procedure fees** are due at time of visit
- **Completed Patient Registration Package**
- **Driver's License** or **State Issued Photo ID**
- **Please bring your current medications you are taking**

NEW PATIENT PORTAL

In order to maintain our status as providers for Medicare, we have been mandated to implement electronic medical records as well as a patient portal. Information that can be completed in the portal before the time of your appointment will help to expedite your time in our office. This may become a requirement to be seen in our office.

In order to utilize the portal, you will enter midlandderm.ema.md into the **Mozilla Firefox** browser and hit enter. **DO NOT** type www or https in front of this address. If you do not currently have Mozilla on your computer, you can download it by going to google.com and searching Mozilla Firefox and download it for free. **DO NOT** use any other browser.

Your login information is as follows:

Username: _____
Password: the first initial of your first name capitalized, then your last name lower case, then the four numbers of the year you were born.
For example: Mmouse1928

This will bring you to a page where you are able to view and edit or add information prior to your appointment. You will see a list of tabs on the left side of the page.

- **Contact Information and Insurance**: Please review and verify all information. It is important that your race and ethnicity are entered for insurance purposes.
- **Pharmacy**: Allows you to enter your pharmacy information so that we can send your prescriptions electronically.
- **Past Medical History**: allows you to enter your medical and surgical history.
- **Skin Disease History**: allows you to enter any previous skin problems
- **Medications**: allows you to enter all of your current medications including most over-the counter medications
- **Allergies**: allows you to enter any known drug allergies
- **Social History**: allows you to document drug, alcohol and smoking history. Please note that the smoking status must be completed.
- **Problem List**: allows you to view any condition that your provider has diagnosed you as having and the date you were given that diagnosis.
- **Tests and Results**: allows you to view any test or lab that was performed or ordered for you. You can also see the results of those tests or labs if they have come back.

REMINDERS OF REQUIRED ITEMS FOR YOUR VISIT

- **Insurance Cards** If you have health insurance, we cannot see you without making a copy of your insurance card.
- **A valid picture ID**
- **A method to pay (**cash, check or credit card) your portion due (co-pay, deductible and coinsurance)
- **Written Referral** from your Primary Care Physician if required by your insurance plan.
- **Cosmetic procedure fees** are due at time of visit, some cosmetic fees may be due prior to visit.
- **Completed Patient Information, HIPAA Privacy Practices** and a signed copy of the **Office Policies and Procedures**
- If you did not complete the Medications tab in the portal **please bring your current medications you are taking**

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HIPAA PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how Russell Akin MD PLLC may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. The Notice is available to you on our website and at the front desk at your request. You may review the Notice before signing this consent. As a patient, you have the right to request restrictions on use and disclosure of your health information.

Disclosures of your health information or its use for any purpose other than those listed in our "Notice of Privacy Practices" and/or consent require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Persons Authorized to Receive Information About Your Care:
I authorize Russell Akin MD PLLC to release all information regarding my financial account, appointments, pathology results, treatment and/or other information pertinent to my healthcare provided by Russell Akin MD PLLC over the telephone or in person to the following person(s) (i.e. spouse, family member, etc.):

Name of Person	Relationship to Patient	Telephone Number

I do not authorize the following information to be disclosed to any other parties except to me as the patient. (Please specify):
_____

Communication:
I authorize Russell Akin MD PLLC to leave messages in reference to any items that assist in carrying out healthcare operations including appointment reminders, biopsy results, and billing issues.

Home phone: □ YES □ NO Cell phone: □ YES □ NO Work Phone: □ YES □ NO

By signing this form, you acknowledge that you have read and understand our Notice of Privacy Practices and consent to our use and disclosure of protected health information about you for the purpose of treatment, coverage and payment from your health insurance company and overall health care operations. You have the right to revoke this consent in writing with your signature. By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me."

Signature of Patient/Legal Representative: _____ Date: ____/____/____

Name of Patient/Legal Representative: _____

Signature of Staff Member: _____ Date: ____/____/____

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OFFICE POLICIES AND PATIENT RESPONSIBILITIES

Updated: July 2018

Thank you for choosing Midland Skin Cancer Center MD PLLC for your skin care needs. It is our goal to provide you with a positive experience. Over the past few years, the practice of medicine has become more complicated for physicians and patients alike.

Because of the growing complexity of the insurance business, we feel that we can no longer assume that patients fully understand the relationship between the insurance company, the physician, and themselves. In an effort to clarify this relationship, we have established a set of guidelines regarding financial responsibility and office policies.

We will file your insurance for you if we are in your network

- When making an appointment with one of our providers, it is your responsibility to confirm with your insurance company that the physician/provider is currently under contract with your plan. If your insurance is a plan for which we are not a contracted provider, we are more than willing to provide care but the total cost of your visit will be your responsibility at the time of service.
- It is your responsibility to understand your insurance plan coverage. If you do not understand your policy, you may wish to contact the number on the back of your insurance card to review and verify your benefits. Not all services are a covered benefit in all contracts. Some insurance companies select certain services or diagnosis codes that they will not cover. Our office never guarantees that your insurance will pay for all services. We will make every attempt to file your claim as straightforward and simple as possible. However, if for any reason your claim is denied, you are responsible for the amount due on your account.

Referrals

- With some insurance plans, you may be required to see a Primary Care Physician (PCP) in order to see a dermatologist or other specialist. If your plan requires authorization by a PCP, you must obtain a referral prior to scheduling your visit. If your plan requires a referral and you or your PCP does not provide one by your scheduled appointment time, please be prepared to pay for your visit in full or reschedule.

Copayments, Deductibles and Coinsurance

- A copayment is a set dollar amount you owe for each office visit. All claims are subject to a deductible if a procedure is performed (i.e., biopsy, cryosurgery, Mohs, excisions, etc.). A deductible is the amount you are obligated to pay before your insurance company starts paying for your healthcare costs. Some insurance plans may also have a coinsurance, in which you may be responsible for a percentage of healthcare costs in addition to your copayment or deductible. It is your responsibility to understand your plan and any associated deductible or coinsurance. Payment will be due at time of service if your deductible has not been met or if your plan requires a coinsurance payment. You may be billed for these amounts should your insurance company notify us that additional payment is due from you.

A valid <u>Picture ID</u> and your <u>Insurance Card</u> are required at the time of your office visit

- Without a valid insurance card, we are unable to file a claim to your insurance company and you will be responsible for the day's charges at the time of service.
- It is your responsibility to notify the staff of any changes in your address, phone number and/or insurance plan, and provide a current up-to-date insurance card at each visit. Failure to do so may cause your insurance claim to be rejected, thus making it your responsibility to pay for the total cost of the visit.

Patients Undergoing Skin Cancer Treatment:

- I understand that if I have a skin cancer and that it is my responsibility to seek follow-up care by Russell Akin MD PLLC personnel or other dermatology professionals. ***Failure seek follow-up care is my responsibility and I do not hold Russell Akin MD PLLC personnel professionally or personally responsible for skin cancer follow-up.***

Not Medically Necessary or Cosmetic Procedures

- Your insurance company may deem certain procedures as not medically necessary, or cosmetic. If you and your doctor/provider decide to continue with a procedure that falls into this category, we require payment in full at the time of service. The following are some examples:
  - Removal of benign lesions (i.e., skin tags, angiomas, sun spots or liver spots, cysts, milia, sebaceous hyperplasia, or seborrheic keratoses, etc.)
  - Botox, fillers such as Restylane and Perlane, scar revisions, cosmetic consults, or cosmetic procedures such as chemical peels, microdermabrasions, and laser hair removal, etc.
  - The cost of any procedure will be a separate fee from an office visit or consultation fee.

Prescription Refill Policy

- Midland Skin Cancer Center requires that you be seen at least once a year in order to maintain any prescription given by our providers. These prescriptions have been written to allow the maximum number of refills the providers feel comfortable giving without having to assess your condition or review or test for side effects. Please keep your follow-up appointments and plan ahead to avoid being without your medication. We do not give prescription extensions if you fail to keep recommended visits.

Laboratory and Pathology Fees

- At times, it may be necessary to obtain a tissue sample (biopsy) or perform lab tests to confirm a diagnosis or determine a course of treatment. If a biopsy or other lab work is done, you will receive a separate bill from the pathologist or laboratory for these tests. If your insurance plan has a preferred provider for blood work or pathology, please notify our office staff prior to any procedure for special handling. Although the lab will file with your insurance, you are responsible for any bill you may receive from the laboratory or pathologist. Please discuss any billing errors or discrepancies with those institutions.

Medical Record Copies

- There is a $25 flat fee for medical record copies up to 100 pages. There is an additional $25 fee for each additional 100-page increment (any number of pages up to 100). This fee covers the cost of our staff and supplies required to make copies.

Check-In

- Your time is important to us. The first step in keeping your appointment on time is being prepared. This includes filling out all required paperwork prior to your first appointment. It is extremely important that you provide each piece of information that is requested on both the Patient Information and Medical History Questionnaire. This will avoid delays in creating your chart and account at your visit. Please arrive at least 15 minutes prior to your scheduled time so that all paperwork may be completed BEFORE you are scheduled to see the provider.

Missed Appointments, Late Cancellations, Late Arrivals and Non-Compliance

- Please keep in mind that appointments are time-slots reserved specifically for you. We require a 24-hour advance notice if you are unable to keep your scheduled appointment. For your convenience, we offer appointment reminder calls 48 hours prior to your appointment that will allow you to cancel at that time. However, it is ultimately your responsibility to keep track of your appointments whether you receive a reminder call or not.
- If you miss an appointment without a 24-hour notice or cancel the same day as your appointment a $25.00 cancellation fee may be assessed to your account. Surgery/cosmetic patients who fail to contact us for cancellation or whom no-show may have a $50.00 fee assessed to your account. This fee is not billable to your insurance.
- We do our best to keep to the schedule. When a patient arrives late, it is impossible to stay on schedule. If you arrive more than 15 minutes past your scheduled appointment time, you may be rescheduled so that other patients are not inconvenienced.
- At times, a surgery may take longer than anticipated or a patient has been worked in for an emergency that may cause our providers to run late. You won't be rushed when you see the doctor and your patience is appreciated if we are running behind.
- Patients with multiple cancellations or missed appointments may be discharged from our practice.
- Please note that noncompliance with treatment plans (including medications and/or lab work) and abusive/inappropriate behavior towards staff and/or patients will result in immediate dismissal of your care from our practice.

Forms of Payment

- We accept payment in the form of cash, check, MasterCard, Visa, Discover and American Express.
- Instacheck processes any checks returned to us due to insufficient funds. In addition to charges assessed by Instacheck, we will assess a $30 fee for all returned checks.

Collection Fees

- We will send you three statements regarding your balance. The second statement is considered past due. If you should receive a third statement noted "Final", the account balance will be turned over to a collection agency. If your account is turned over to a collection agency, you will be discharged from the practice.

Minors

- The parent(s) or guardian(s) of minor patients MUST accompany the child for the initial evaluation and sign an informed consent to treat the child. Future visits will be covered under this consent. It is the responsibility of the parent or guardian to provide current insurance information and payment in full for services provided, should the child be unaccompanied at future visits. In cases of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those charges. If the divorce decree requires the other parent to pay all or part of the costs, it is the authorizing parent's responsibility to collect from the other parent.

Policy On Electronic Devices

- In observance of the confidentiality rights of other patients and out of respect for the privacy of our employees and physicians, ***please either turn off your cell phone or place it on silent. Video or audio recordings in this office are strictly prohibited.*** You are welcome to take notes during your visit, and please remember that all medically necessary information is documented in detail in your medical record.

I have read, understand and agree to the above office and financial policies of Russell Akin MD PLLC. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing by signing this statement. My signature below states my agreement and understanding of the Russell Akin MD PLLC office and financial policies and also serves as a request and consent for treatment. I authorize and assign all benefit payments to be made directly to Midland Skin Cancer Center.

Signature of Patient/Legal Representative: _____ Date: ____/____/____

Name of Patient/Legal Representative: _____

Name: _____ Date of Birth: _____/_____/_____

HISTORY AND INTAKE FORM

Past Medical History: (please mark all that apply):

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH (Benign Prostatic Hyperplasia)
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (Emphysema)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ **HIV/AIDS**
- ☐ Hypertension
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker/Defibrillator
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ None
- ☐ **Artificial Joints If so, year _____**
- ☐ **Hepatitis C**

Other _____

Past Surgical History: (please list all prior surgeries)

Skin Disease History: (please mark all that apply):

- □ Acne
- □ Actinic Keratoses
- □ Basal Cell Carcinoma
- □ Eczema
- □ None
- □ Melanoma
- □ Precancerous (Dysplastic) Moles
- □ Psoriasis
- □ Squamous Cell Carcinoma

Other _____

Do you have a family history of Melanoma? □ Yes □□ No
If yes, which relative(s)? _____
Any other family history: _____
If you checked yes, it is recommended and you will be asked to have a total body skin examination that is a fully disrobed exam.

THIS FORM IS CONTINUED ON BACK

HISTORY AND INTAKE FORM
Page 2

Current Medications: (prescribed, supplements/herbs, non-prescribed)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: (medications, latex, food)

Hospice:
Are you currently in Hospice? □ Yes □□ No
If yes, what is your Hospice diagnosis? _____

Social History: (please mark all that apply)

Cigarette Smoking:
- □ Never Smoked
- □ Quit: Former smoker
- □ Smokes less than daily
- □ Smokes daily – cigarettes
- □ Uses tobacco daily

Alcohol Use:
- □ None
- □ Less than 1 drink per day
- □ 1-2 drinks per day
- □ 3-4 drinks per day
- □ 5 or more drinks per day

Language:
- □ English
- □ Spanish
- □ Other: _____

Race:
- □ White
- □ Black/African American
- □ Asian
- □ American Indian or Native Alaskan
- □ Native Hawaiian/Pacific Islander

__ How many times in past year have you had 5 (for men) or 4 (for women or adults older than 65 years) drinks per day

Ethnicity:
- □ Hispanic/Latino
- □ Non-Hispanic/Latino

Pharmacy:
Name: _____
Street Location: _____

Occupation: _____

Patient Name: _____ Date of Birth _____/_____/_____

ADDITIONAL HISTORY AND INTAKE QUESTIONS
AS REQUIRED BY MEDICARE AND
NEW HEALTHCARE REGULATIONS

Who is your primary care provider _____?

Who is your referring provider if not your primary care provider _____?

Influenza Vaccine: (for patients 6 months AND older)
Please check the one that best fits:
□ Received a flu vaccine this flu season.
□ Did not receive a flu vaccine this flu season because of medical reasons.
□ Did not receive a flu vaccine this flu season because I did not want one.
□ Did not receive a flu vaccine this flu season.

Other Vaccines: (For patients who are EXACTLY 13 years old). If you are NOT currently 13 years old, please skip these questions. Please check all that apply.
□ Received 1 dose of meningococcal vaccine on or between my 11^{th}-13^{th} birthdays.
□ Received 1 tetanus, diphtheria and pertussis vaccine (TDAP) on or between my 10^{th} and 13^{th} birthdays.
□ Received at least 3 HPV vaccines on or between my 9^{th} and 13^{th} birthdays.

Pneumococcal Vaccine: (for patients 65 AND older) Please check the one that best fits:
□ Received a pneumococcal vaccine. (Pneumonia)
□ Did not receive a pneumococcal vaccine.

Advanced Directives: (for patients 65 AND older)
Advanced Directives are designed to respect your wishes and determine what future life-sustaining medical treatment you would like, if you are unable to indicate those wishes on your own. Key interventions and treatment decisions are: Resuscitation procedures such as cardiopulmonary resuscitation (CPR), and mechanical respiration (breathing tube).

Which statements **best reflect** your wishes on advanced care recommendations?
□ I want full cardiopulmonary resuscitation efforts to be made. (Full Codes).
□ I do not wish to have a breathing tube, even if it is necessary to save my life. (Do Not Intubate)
□ If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart even if necessary to save my life. (Do Not Resuscitate)
□ I have a living will. (A living will is a document that you have in place that specifies the type of care that you would like to receive in the event that you are incapacitated or names another person to make those decisions for you.)
□ I have a health care proxy who name is _____ and whose contact information is _____.

_____ _____/_____/_____
Patient/Patient Representative Signature

NOTICE OF PRIVACY PRACTICES
Russell Akin MD PLLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY HAVE ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

We reserve the right to revise or amend this Notice of Privacy Practices at any time. 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 future. You may request a copy of our most current Notice at any time.

Ways in Which We May Use and Disclose Your Protected Health Information:

The following paragraphs describe different ways in which we may use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

- **Treatment.** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. *For example* – We may ask you to have laboratory tests such as blood, urine or skin biopsy and we may use the results to help us reach a diagnosis. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.
- **Payment.** We will use and disclose your protected health information to obtain payment for the health care services we provide you. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.
- **Health Care Operations.** We will use and disclose your protected health information to support the business activities of our practice. *For example* – we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

Ways in Which We May Use and Disclose Your Protected Health Information

- **Appointment Reminders.** We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.
- **Treatment Alternatives.** We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.
- **Others Involved in Your Care.** We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.
- **Research.** We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- **As Required by Law.** We will use and disclose your protected health information when required by federal, state, or local law. You will be notified of any such disclosures.
- **To Avert a Serious Threat to Public Health or Safety.** We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that heath authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.
- **Military.** We will use and disclose your protected health information if you are a member of the U.S., or foreign military forces (including veterans) and if required by appropriate authorities.
- **National Security:** We will use and disclose your protected health information to federal officials for intelligence and national security activities authorized by law.
- **Worker's Compensation.** We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illnesses.
- **Inmates.** We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

- **A Paper Copy of This Notice.** You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.
- **Inspect and Copy.** You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. If you wish to inspect or copy your medical information, you must submit your request in writing to our ***Privacy Officer at Midland Skin Cancer Center 4214 Andrews Highway Suite 100b Midland TX 79703.*** You may mail in your request or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.
- **Request Amendment.** You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to Office manager , stating exactly what information is incomplete or inaccurate and your reasoning that supports your request. We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:
    - the information was not created by us, or the person who created it is no longer available to make the amendment;
    - the information is not part of the record which you are permitted to inspect and copy;
    - the information is not part of the designated record set kept by this practice;
    - or if it is the opinion of the health care provider that the information is accurate and complete.
- **Request Restrictions.** You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. *For example* – you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our Office Manager. We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.
- **An Accounting of Disclosures.** You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulations) nor for a period of time greater than six years (our legal obligation to retain information). Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.
- **Request Confidential Communications.** You have the right to request how we communicate with you to preserve your privacy. *For example* – you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or when we are to contact you. We will accommodate all reasonable requests.
- **File a Complaint.** If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice manager or directly to the Secretary of Health and Human Services. To file a complaint with our practice you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to Office Manager- Russell Akin MD PLLC 4214 Andrews Highway Suite 100 B Midland TX 79703. You should know that there would be no retaliation for your filing a complaint.

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

For More Information

If you have questions or would like additional information, you may contact our office manager at above number.

Midland Skin Cancer Center
4214 Andrews Highway Suite 100 B
432-689-2512
Fax 432-689-2108

Patient information			
Patient Name (Last, First, M.I.)	Date of Birth / /	Cell Phone	Home phone
Address	City	State	Zip code
SSN	Driver License #	Marital status M S D W	Preferred Communication Home Cell Work Email
Emergency Contact Information			
Name (Last, First)	Relationship	Cell #	
Address	City	State	
Name (Last, First)	Relationship	Cell #	
Insurance Information			
Policy Holder's Name	Relationship to patient	SSN of Policy Holder	Date of Birth Policy Holder
Policy Holder Address	City	State	Zip
Parent or Guardian information			
Name (Last, First)	Work Number	Cell phone	Home phone
Address	City	State	Zip
SSN	Driver License #	Relationship	

I hereby consent and authorize to treatment of the above listed patient by the physicians and staff of Midland Skin Cancer Center. If appropriate, I hereby authorize and consent without exclusion to the release of medical information for the purpose of processing insurance claims on my behalf. I understand that it is my responsibility to provide current and up to date information for the processing of claims. I UNDERSTAND THAT THE FILING OF INSURANCE CLAIMS IS NOT A GUARANTEE OF PAYMENT AND THAT ULTIMATELY I AM PERSONALLY RESPONSIBLE FOR ANY AND ALL UNPAID CLAIMS OR CHARGES THAT RESULT FROM THE CARE PROVIDED. THIS INCLUDES ANY UNPAID CLAIMS OR DENIED CLAIMS.
I authorize payment of medical benefits directly to Midland Skin Cancer Center/Russell Akin MD PLLC.

I understand that I am ultimately responsible for services that are provided to me and I acknowledge that any agreement is between the patient and the insurance company. Delinquent accounts are subject to collections and attorney's fees if appropriate.

If a parent or guardian, I attest that I have the legal authority to sign these documents and in turn am responsible for payment of any services provided to include copays, deductibles and co-insurance.

I authorize Midland Skin Cancer Center to fax or provide records as necessary to any physician or pharmacy involved in the care of me as a patient, to coordinate or provide continuing care to me as a patient. I authorize Midland Skin Cancer Center to take photographs for the purpose of documentation in the chart. These photos will only be used for the purpose of documentation in the patients chart but may be shared with other providers involved in the patients care or for the purpose of documentation and provided to the patients insurance company to document care provided.

_____ _____

Signature (patient /parent – guardian) Date