



PLEASE READ, IMPORTANT INFORMATION

Dear Patient,

Please fill out the enclosed paperwork and bring it with you to your appointment. If you want to mail it back to us, PLEASE ALLOW AT LEAST A WEEK FROM THE DAY OF YOUR APPOINTMENT, OTHERWISE WE MAY NOT RECEIVE IT IN TIME and you will be expected to fill out more paperwork on the day of your appointment. If you are unable to fill out your paperwork, please have someone at home help you or bring someone with you that can help you. Also BE SURE THAT YOU BRING YOUR INSURANCE CARDS and your drivers license to be copied. WE CANNOT FILE YOUR INSURANCE WITHOUT YOUR ACTUAL INSURANCE CARD! Otherwise your appointment will be rescheduled. We do not bill for copays. You will be responsible for your copay or deductible on the day of your appointment. We do not call and get your insurance benefits. If your insurance requires a Referral Number, please make sure you obtain one from your primary care physician BEFORE your appointment. If one is not obtained before your appointment, your appointment will be rescheduled OR you will be required to pay in full. We will file the insurance, but you will be reimbursed out of network benefits from us or your insurance company. If you do not have insurance, PAYMENT IS REQUIRED IN FULL at the time of service.

If you have any questions regarding this letter, please call before the day of your appointment.

Thank You

HIPAA NOTICE OF PRIVACY PRACTICES

Stephen J. Beck, M.D.
Dermatology and Skin Cancer Clinic, P.A.
901 Walnut Hill Drive
Longview, Texas 75605-5054
(903) 757-8878

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

This Notice of Privacy Practices describes how Dermatology & Skin Care Clinic, P.A. may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control of your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by Dr. Stephen J. Beck, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: Dermatology & Skin Cancer Clinic, P.A. will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care service. For example, obtaining approval for surgery in our office may require that your relevant protected health information be disclosed to the health plan to obtain approval for the surgery.

Healthcare Operations: Dermatology & Skin Cancer Clinic, P.A. may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your appointment time. We may also call you by name in the waiting room when Dr. Beck is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, or of a missed appointment.

Dermatology & Skin Cancer Clinic, P.A. may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization at any time in writing, except to the extent that Dr. Beck or Dermatology & Skin Cancer Clinic, P.A. has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Dr. Stephen Beck is not required to agree to a restriction that you may request. If Dr. Beck believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information. If Dermatology & Skin Cancer Clinic, P.A. denies your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

Dermatology & Skin Cancer Clinic, P.A. reserves the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

Dermatology & Skin Cancer Clinic, P.A.



STEPHEN J. BECK, M.D.
Diplomate American Board of Dermatology

901 Walnut Hill Drive
Longview, Texas 75605
(903) 757-8878

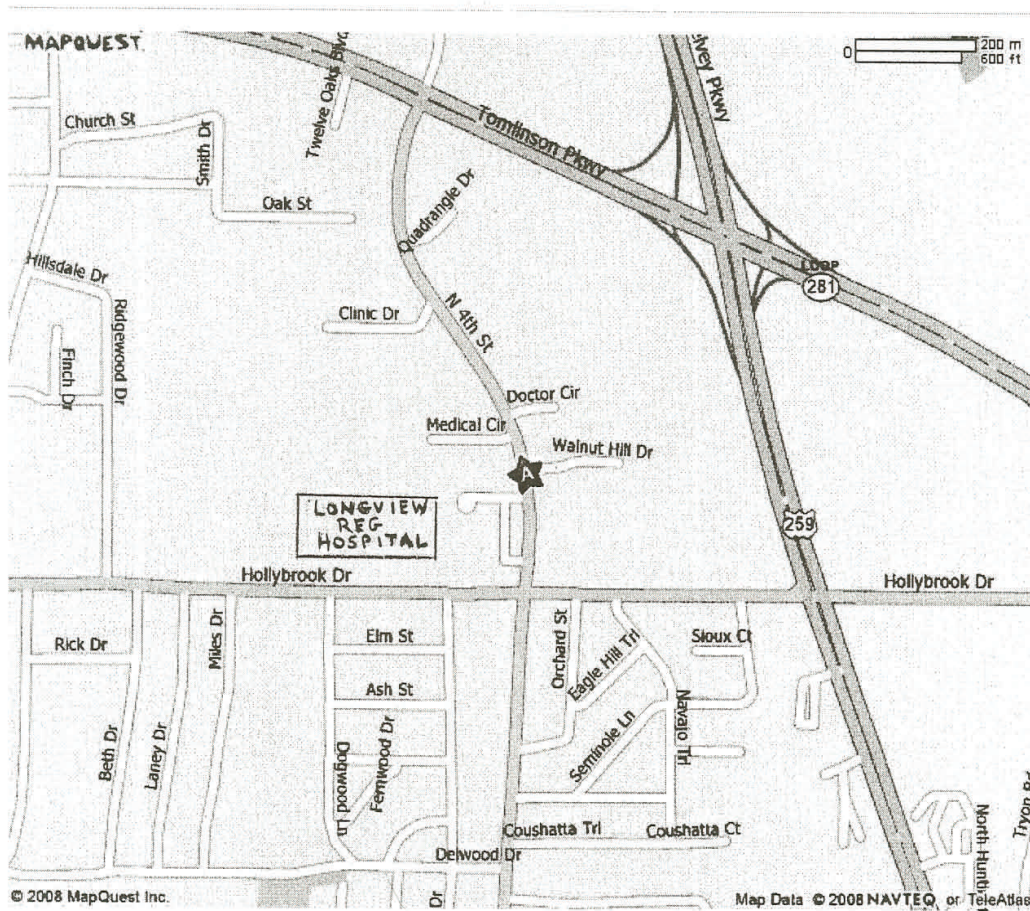
Dermatology & Skin Cancer Clinic, P.A.



STEPHEN J. BECK, M.D.
Diplomate American Board of Dermatology

DENIS ADAMS, PA-C
Physicians Assistant / Certified

901 Walnut Hill Drive
Longview, Texas 75605
(903) 757-8878



MINOR PATIENT REGISTRATION FORM

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: TODAY'S DATE ____/____/____

Name: _____
Last First Middle

Prefer to be called: _____

Date of Birth: ____/____/____ Sex: Male Female Social Security Number: ____-____-____

Mailing Address _____
City State Zip

Home Phone: () _____

Mother's Name: _____
Last First Middle

Mother's Date of Birth: ____/____/____ Social Security Number: ____-____-____

Employer: _____ Employer Phone: () _____

Father's Name: _____
Last First Middle

Father's Date of Birth: ____/____/____ Social Security Number: ____-____-____

Employer: _____ Employer Phone: () _____

INSURANCE COVERAGE—PRIMARY:

Insurance Co. Name: _____

Name of Policy Holder (Insured): _____

Policy Holder (Insured) Date of Birth: ____/____/____

INSURANCE COVERAGE—SECONDARY:

Insurance Co. Name: _____

Name of Policy Holder (Insured): _____

Policy Holder (Insured) Date of Birth: ____/____/____

FINANCIAL POLICY:

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the policies of our office.

It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service (e.g., deductible, co-payments, and non-covered services.)

_____/_____/_____
Signature of parent or legal guardian Date

Please present insurance card(s) and photo ID to the receptionist so copies can be made.

**REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND
SIGNATURE ON FILE**

Patient Name: _____ Today's Date: ____/____/____

Referred By: _____

Primary Care Physician: _____ Phone: () _____

EMERGENCY CONTACT INFORMATION:

In case of emergency, who should be notified? _____

Relationship: _____ Phone: () _____

Do you give our office permission to discuss your medical information (biopsy results, etc.) with family members? YES NO If yes, please provide their names and phone numbers below.

(1) Name: _____ Relationship: _____

Phone (day): () _____ Phone (evening): () _____

(2) Name: _____ Relationship: _____

Phone (day): () _____ Phone (evening): () _____

May we discuss financial information with family members? YES NO

May we leave personal medical information (biopsy results, etc.) on your answering machine at home?

YES NO

Do we have permission to use an automated telephone system to confirm your appointment?

YES NO

May we e-mail personal medical information to you?

YES NO E-mail address: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and./or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature: _____ Date: ____/____/____

PAYMENT POLICY:

PPO or other managed care patients: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered, cosmetic services at the time of service. For your convenience, we accept Visa, Mastercard and Discover.

Patient or Responsible Party Signature: _____ Date: ____/____/____

