

Patient Registration

Patient Information

Name _____ Birth Date ____-____-____ Age _____
Previous name _____ Soc. Sec. #: ____-____-____
Address _____ Home No. () ____-____
City _____ State _____ Zip _____ Work No. () ____-____
Single Married Widowed Mobile No. () ____-____
Name of nearest relative not living in same household _____ Fax No. () ____-____
Relative's phone no. () _____ Religious Preference: _____
Relationship: _____

Patient's Employer Information

Company/Employer _____ Occupation _____

Spouse Information if married / Parent's information if you are currently covered on parent's insurance plan

Name _____ Soc. Sec. # ____-____-____ Date of Birth ____-____-____
Employer _____ Work No. () ____-____
Occupation _____

Primary Insurance Carrier

Please Complete in Detail

Insurance Company _____

Address _____

City/State/Zip _____

Insured Date of Birth: ____-____-____

ID or Policy Number _____

Group Number _____

Your relationship to insured:

Self Spouse Parent Other

Secondary Insurance Carrier

Please Complete in Detail

Insurance Company _____

Address _____

City/State Zip _____

Insured Date of Birth: ____-____-____

ID or Policy _____

Group Number _____

Your relationship to insured:

Self Spouse Parent Other

Patient's Approval

I understand that I am personally responsible for the full amount of my charges regardless of my insurance coverage. I hereby assign medical benefits to Sally M. Knox, M.D., and authorize the release of any medical information required by my insurance company

× _____
Patient's Signature

Date

Sally M. Knox, M.D., P.A
PATIENT INFORMATION

Name: _____ Date of birth: ____ - ____ - ____ Age: ____

Single Married Widowed Race: _____

Referred by: _____

Reason you came for evaluation: _____

	RIGHT	LEFT
Lumps in breast now?	_____	_____
Nipple discharge?	_____	_____
Breast pain or soreness?	_____	_____
Injury to the breast?	_____	_____

Give details including when and how discovered: _____

Have you had a mammogram previously? _____ Date(s): _____

If yes, where? _____ Results: _____

List previous breast surgery or problems: type of procedure, date, and physician: _____

Number of previous breast biopsies? _____

Do you have a personal history of cancer other than breast? _____

If yes, list type, age, physician and treatment: _____

Family history of breast cancer? Yes ____ No ____

	Age		Age
Mother	_____	Maternal Grandmother	_____
Sister	_____	Paternal Grandmother	_____
Daughter	_____	Maternal Aunt	_____
		Paternal Aunt	_____

Family history of other cancers: (i.e. colon, ovarian, prostate, melanoma, other) Give details, type and age.

Do you practice breast self exams? _____ How often? _____

	Yes	No	Dates
Do you take or have you taken: Birth control pills	_____	_____	_____
Estrogen	_____	_____	_____
Progesterone	_____	_____	_____
Cortisone	_____	_____	_____

Date _____

Date: _____

Name : _____

Age of first menstrual cycle: _____

Date of last period: _____

Age of menopause: _____

Give number of pregnancies: _____ Age of first pregnancy _____

Number of live births: _____ Are you pregnant? _____

Did you breast feed? _____ If yes, how long? _____

Have you had a hysterectomy? _____ Date _____

Reason: _____ Surgeon _____

Have your ovaries been removed? _____ Date _____

Reason _____ Surgeon _____

What is your height? _____ Weight _____

Are you being treated for diabetes, heart problems, bleeding disorders, or other medical conditions? Indicate anything you are under a physician's care for and the physician's name.

Previous surgery other than breast? List procedure, date and surgeon.

Prescription medicines? Name of medication, dosage, how often taken.

Do you take aspirin regularly? _____

Do you take pain relievers or other "over the counter" supplements or medications? If yes, list.

Drug allergies? _____

List drug reaction? _____

Tape or soap allergies? _____ Details: _____

Do you have a history of smoking? _____ Are you currently smoking? _____

How many years? _____ How much? _____

How many alcoholic beverages do you average each week? _____ Or month? _____

How many caffeine-containing beverages do you consume each day? _____

Sally M. Knox, M.D., P.A.

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Notice of Privacy Practices

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 practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the Privacy Officer, Jan Pinkston @ 214/826-9797.

Treatment, Payment, Health Care Operations

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of a specialist. When we refer you to a specialist, we will share some or all your medical information with that physician to facilitate the delivery of care. 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.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and you are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- Is about a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation

We may disclose your medical information as required by the Texas workers' compensation law.

Inmates

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law

We may release your medical information where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed below.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of

Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the *lower* of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set?
- Is not available for inspection because of an appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request *before* any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits

We may contact you by telephone, U.S. Postal mail or email to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Jan Pinkston-Privacy Officer
3535 Worth St.
Ste. 610
Dallas, Texas 75246
214/826-9797
Fax: 214/828-2089
Email: dr.sallyknox@smknox.com

This notice is effective on the following date February 1, 2003

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

HIPPA CONSENT FORM

TO THE USE AND/or DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR THE TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND AS OTHERWISE ALLOWED BY LAW.

Sally M. Knox, M.D., P.A. (hereinafter “Dr. Knox”) will maintain a record of the care and services you receive at our office. This consent only covers your protected health information created while you are a patient at the office of Dr. Knox. Your protected health information pertains to your diagnosis and/or treatment with Dr. Knox including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus (“HIV”) and Acquired Immune Deficiency Syndrome (“AIDS”), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to allow the office of Dr. Knox to use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. Our *Notice of Health Information Practices* provides information about how the office of Dr. Knox may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

By signing this form, you also acknowledge that you have been given an opportunity to view a copy of Sally M. Knox, M.D., Notice of Privacy Practices before signing this consent. This notice was provided by the staff of Sally M. Knox, M.D., P.A.

Signature of Patient or Legal Representative

Witness

Printed Name

Date

CONFIDENTIALITY FORM

The "Office of Dr. Sally Knox" has my permission to send correspondence to the following **PHYSICIANS (MD's or D.O.'s only)** concerning my medical information:

PHYSICIAN'S Full Name	Specialty	Address	Phone
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1. _____

2. _____

3. _____

I give my permission allowing the "Office of Dr. Sally M. Knox" to discuss my medical information with the **FOLLOWING INDIVIDUALS**:

Name	Relationship	Phone
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1. _____

2. _____

3. _____

4. _____

The "Office of Dr. Sally M. Knox" has my permission to contact me via email regarding my medical information.

Email Address: _____

May we leave a voice message at the following locations?

(If yes, provide number below)

Home _____

Work _____

Mobile _____

Patient or Legal Guardian Signature

Relationship

Printed Name

Date