REGISTRATION FORM

PATIENT NAME: _____

STREET ADDRESS: _____ APT/UNIT #: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ EXT: _____ EMPLOYER: _____

GENDER: M / F MARITAL STATUS: SINGLE MARRIED SEPERATED WIDOW

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

EMERGENCY CONTACT: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN PATIENT)

NAME: _____ DATE OF BIRTH: _____

STREET ADDRESS: _____ APT/UNIT #: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

ALL MINORS MUST BE ACCOMPANIED BY AN ADULT OR HAVE A SIGNED AUTHORIZATION FORM ON FILE (AVAILABLE UPON REQUEST)

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____

POLICY #: _____ GROUP #: _____

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP: _____ SOCIAL SECURITY #: _____

SECONDARY INSURANCE CARRIER: _____

POLICY #: _____ GROUP #: _____

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP: _____ SOCIAL SECURITY #: _____

PATIENT APPOINTMENTS ARE CONFIRMED THE DAY PRIOR TO YOUR VISIT. PLEASE INDICATE THE METHOD WHICH IS MOST CONVENIENT, IF WE ARE UNABLE TO SPEAK DIRECTLY WITH YOU.

____ LEAVE MESSAGE ON VOICEMAIL

____ LEAVE MESSAGE WITH SPOUSE OR HOUSEHOLD MEMBER

____ LEAVE MESSAGE AT WORK

____ OTHER _____

PLEASE LIST ANY FAMILY MEMBER(S) THAT WE MAY DISCUSS YOUR MEDICAL INFORMATION WITH, IF ANY.

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

PLEASE READ THE FOLLOWING AGREEMENT AND SIGN BELOW:

I ACKNOWLEGE THAT I HAVE RECEIVED A COPY OF THE PRIVACY POLICY AND FINANCIAL OBLIGATION AND THAT I AUTHORIZE THE OFFICE OF DR. MELVIN LU TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF TREATMENT AND PAYMENT, AS DESCRIBED IN THE PRIVACY POLICY.

X_____ DATE: _____

(PATIENT SIGNATURE OR AUTHORIZED REPRESENATIVE)

MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

REFERRING PHYSICIAN: _____ PHONE #: _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING OVER THE COUNTER, VITAMINS AND HERBALS)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

DO YOU HAVE ANY KNOWN ALLERGIES? ____ YES _____ NO (IF YES, PLEASE LIST DOWN BELOW)

_____ _____

_____ _____

_____ _____

_____ _____

DO YOU HAVE NOW, OR HAVE EVER HAD THE FOLLOWING CONDITIONS? (PLEASE CIRCLE YES OR NO)

HEART MURMUR	YES	NO	IMMUNODEFICIENCY/HIV	YES	NO
ASTHMA	YES	NO	DIABETES	YES	NO
EMPHYSEMA	YES	NO	KIDNEY DISEASE	YES	NO
SEASONAL ALLERGIES	YES	NO	THYROID DISEASE	YES	NO
TUBERCULOSIS	YES	NO	HEPATITIS	YES	NO
HIGH BLOOD PRESSURE	YES	NO	ARTHRITIS	YES	NO
LUPUS, SCLERODERMA	YES	NO	ARTIFICIAL HEART VALVE	YES	NO
PACEMAKER/DEFIBRILLATOR	YES	NO	NEUROLOGIC DISORDER	YES	NO
BLEEDING DISORDER	YES	NO	EMOTIONAL DISORDER	YES	NO
BLOOD CLOT	YES	NO	STD'S	YES	NO
CANCER	YES	NO	JOINT REPLACEMENT	YES	NO
BLADDER, PROSTATE	YES	NO	OTHER _____		

GLAUCOMA YES NO (IF YES, PLEASE ANSWER) OPEN ANGLE / CLOSED ANGLE

PATIENT NAME: _____ DATE OF BIRTH: _____

SKIN HISTORY:

HAVE YOU HAD SKIN CANCER? Y N IF YES, WHAT TYPE _____

DO YOU HAVE A FAMILY HISTORY OF SKIN CANCER? Y N IF YES, WHAT TYPE _____

DO YOU HAVE A HISTORY OF SKIN DISEASES? Y N

DO YOU HAVE A HISTORY OF MRSA OR STAPH INFECTION? Y N

DO YOU HAVE SKIN ALLERGIES? Y N

ARE YOU ALLERGIC TO ANTIBIOTIC OINTMENT OR ADHESIVE TAPE? Y N

DO YOU SMOKE? Y N IF YES, HOW MUCH? _____

DO YOU DRINK ALCOHOL? Y N IF YES, HOW MUCH? _____

DO YOU BLEED EASILY? Y N

WHAT IS YOUR OCCUPATION? _____

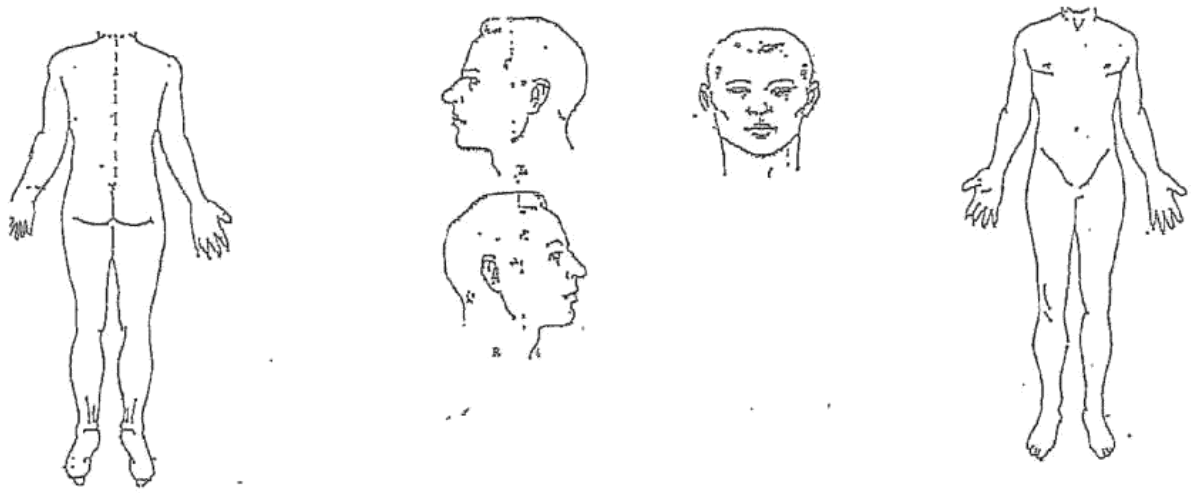
DO YOU HAVE PETS? Y N IF YES, WHAT TYPE(S)? _____

WHAT ARE YOUR HOBBIES? _____

WHERE WERE YOU BORN? _____

THE AMERICAN ACADEMY OF DERMATOLOGY RECOMMENDS A TOTAL BODY SKIN EXAMINATION AT LEAST YEARLY. IF YOU HAVE A HISTORY OF SKIN CANCER, MORE FREQUENT SKIN EXAMS ARE RECOMMENDED. WOULD YOU LIKE TO HAVE A FULL SKIN EXAM ON THE INITIAL VISIT? Y N

PLEASE MARK ANY AREAS OF CONCERN:



SIGNATURE OF COMPLETION X_____ DATE: _____

PATIENT PRIVACY NOTICE EFFECTIVE: SEPTEMBER 23, 2013

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by federal and state laws to maintain the privacy of protected health information. We are also required to give this notice about our legal duties and privacy practices regarding health information about you. We are required to follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our Privacy Officer.

FOR TREATMENT. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

FOR PAYMENT. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

FOR HEALTH CARE OPERATIONS. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family. We may also notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

RESEARCH. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS

AS REQUIRED BY LAW. We will disclose Health Information when required to do so by international, federal, state or local law.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY. We may use and disclose Health Information when necessary to prevent serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help the threat.

BUSINESS ASSOCIATES. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services on our behalf. All of our business associates are obligated to protect the privacy of your

information and are not allowed to use or disclose any information other than as specified in our contract.

ORGAN AND TISSUE DONATION. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

MILITARY AND VETERANS. If you are a member of the armed forces we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

WORKERS' COMPENSATION. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

PUBLIC HEALTH RISKS. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

HEALTH OVERSIGHT ACTIVITIES. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

DATA BREACH NOTIFICATION PURPOSES. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

LAWSUITS AND DISPUTES. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

LAW ENFORCEMENT. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for the duties.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

INMATES OR INDIVIDUALS IN CUSTODY. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to

provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement.

DISASTER RELIEF. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS

YOU HAVE THE FOLLOWING RIGHTS REGARDING YOUR HEALTH INFORMATION WE HAVE ABOUT YOU:

RIGHT TO INSPECT AND COPY. You have the right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other that psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the contact person listed herein. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing and other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and will comply with the outcome of the review.

RIGHT TO ELECTRONIC COPY OF ELECTRONIC MEDICAL RECORDS. If your Protected Health Information is maintained in an electronic format, you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

RIGHT TO GET NOTICE OF A BREACH. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

RIGHT TO AMEND. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the contact person listed herein.
RIGHT TO AN ACCOUNTING OF DISCLOSURES. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and healthcare operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the contact person listed herein.
RIGHT TO REQUEST RESTRICTIONS. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or healthcare operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the contact person listed herein. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or healthcare operation purposes and such information you wish to restrict pertains solely to healthcare item or service for which you have paid us "out of pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with the emergency treatment.
OUT OF POCKET PAYMENTS. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or healthcare operations, and we will honor that request.
RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS. You have the right to request that we communicate with you about medical matters in a certain way or at certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the contact person listed herein. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.
RIGHT TO PAPER COPY OF THIS NOTICE. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our contact person. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

Name of contact person: Brianne Miller
(352)596-4401

FINANCIAL POLICY

Thank you for choosing Melvin C. Lu, M.D. for your dermatological and surgical needs. We are committed to providing you with quality care and to do so we have initiated the following office policies:

REGISTRATION

In order to file medical services with your insurance carrier, we will need to get your current insurance information along with a photo ID, in order to verify identity. It is your responsibility to notify us of any changes. Please be advised it is ultimately your responsibility to insure the doctor is a provider for your insurance company, failure to do so may result in more out-of-pocket expenses.

CO-PAYMENTS

Co-payments will be collected at the time of your visit. You need to be familiar with your medical insurance benefits. It is your responsibility to understand your insurance coverage for common visits and charges.

GENERAL INSURANCE POLICY

As a convenience to you, our office will file a claim to your current insurance company. However, due to each insurance company offering many options for their healthcare coverage, it is impossible for our staff to determine your coverage and responsibility. Your insurance policy is a contract that is between you and your insurance carrier.

We need to verify active coverage and benefits at the time services are rendered. If we cannot verify benefits prior to your visit, we will reschedule your visit or you may elect to pay out of pocket and submit claim to your insurance company for reimbursement.

When your insurance company processes a claim they will provide you with an Explanation of Benefits. This will explain what your insurance company has agreed to pay. It will also include any patient responsibility.

MEDICARE

For our Medicare patients, Medicare will only pay 80% of the approved amount directly to us. If you do not have a supplemental insurance or if we are not participating with your supplemental insurance you will be expected to pay the 20%. If you carry a supplemental plan, please be sure we have your policy information so that a claim may be filed for you.

FEES

We provide medical records to other physicians at no charge. However, if you request your entire medical record a charge will apply in accordance to Florida guidelines.

For all returned checks there is a $35.00 fee. We will not accept any further checks until the returned check and fees are paid in full.

If you have any questions regarding your account or would like to make a payment using Visa or MasterCard, please contact our office during normal business hours.