M. Ferra Lin-Duffy, DO, FACOS, Breast Surgery

M. Ferra Lin-Duffy, DO, FACOS
Breast Surgeon

10001 S. Eastern Avenue
Suite 108
Henderson, NV 89052
Tel: 702.952.3444
Fax: 702.565.2021

Please Complete ALL Forms and Bring Them with You

COMPREHENSIVE CANCER CENTERS

cccnevada.com | 702.952.3350

Affiliated With
The US Oncology Network

M. Ferra Lin-Duffy, DO, FACOS

10001 S. Eastern Avenue, Suite 108
Henderson, Nevada 89052
Tel: 702.952.3444
Fax: 702.565.2021

Patient name: _____ Date: _____

Age: _____

Referred by: _____

Primary care doctor: _____

Reason for visit: _____

Patient Name: _____

Medical History

Please check if you have a history of any of the following:

Congestive heart failure		**Irritable bowel syndrome**	
Heart attack		**GERD**	
Arrhythmia		**Hiatal hernia**	
Mitral valve prolapse		**Anemia**	
Hypertension		**Blood clots**	
Stroke		**Bleeding disorder**	
High cholesterol		**Arthritis**	
Valvular disease		**Fibromyalgia**	
COPD		**Diabetes**	
Emphysema		**Thyroid disease**	
Pulmonary embolism		**Osteoporosis**	
Sleep apnea		**Osteopenia**	
Chronic bronchitis		**Parkinson's disease**	
Kidney disease		**Seizure disorder**	
Kidney failure		**Migraine headaches**	
Chronic UTI		**Multiple sclerosis**	
Gastritis		**Dementia**	
Crohn's disease		**Bipolar**	
Peptic ulcer		**Cancer**	
Hepatitis			

History of breast cancer: Yes _____ No _____ Year of diagnosis _____
Treatment received:_____
_____
_____

Patient Name: _____

SURGICAL HISTORY

Surgery	Date	Surgery	Date
1) _____	_____	4) _____	_____
2) _____	_____	5) _____	_____
3) _____	_____	6) _____	_____

Previous Blood Transfusions: YES NO **Did you have a reaction?** YES NO

If yes, what was the reaction? _____

Please list Drug Allergies and Reaction:

1) _____ 3) _____ 5) _____

2) _____ 4) _____ 6) _____

MEDICATIONS – VITAMINS – SUPPLEMENTS

Name:	Dose:	Name:	Dose:

Patient Name: _____

SOCIAL HISTORY

Are you currently: Employed Unemployed Retired Disabled

Occupation: _____

Circle One: Single Married Divorced Widowed Separated

Have you ever smoked? Yes No If yes, your age when you started? _____

Average pack per day: _____ Date quit (if applicable): _____

Do you drink? Yes No **If yes, how much per week? _____**

Use of recreational drugs: Yes No **If yes, what type? _____**

Patient Name: _____

FAMILY HISTORY

	Yes	Relationship
Heart disease		
High cholesterol		
High blood pressure		
Stroke		
Diabetes		
Bleeding disorder		
Blood clots		

Are you of Ashkenazi Jewish descent? Yes No

FAMILY CANCER HISTORY

Family Member	Type of Cancer	Age at Diagnosis	Living	Deceased

Patient Name: _____

OB/GYN HISTORY

Age of first menstrual cycle: _____ **Date of last menstrual cycle: _____**

Are you currently pregnant? YES NO

# of pregnancies: _____ **# of live births: _____**

Age of first pregnancy: _____ **Age of first live birth: _____**

History of breast feeding?
YES NO

History of Hormone Replacement Therapy?
YES NO

If yes, for how long: _____

History of Birth Control Pills?
YES NO

If yes, for how long: _____

Patient Name: _____

CURRENT SYMPTOMS:

Please check if you CURRENTLY have any of the following symptoms:

Fatigue		**Vomiting**	
Weight change		**Heartburn**	
Insomnia		**Constipation**	
Hot flashes		**Diarrhea**	
Sinusitis		**Hemorrhoids**	
Ringing in the ear		**Burning with urination**	
Visual changes		**Blood in urine**	
Difficulty swallowing		**Need to urinate at night**	
Hoarseness		**Incontinence**	
Sore Throat		**Vaginal discharge**	
Chest pain		**Vaginal dryness**	
Palpitations		**Irregular periods**	
Ankle swelling		**Painful periods**	
Cough		**Heavy periods**	
Shortness of breath		**Muscle pain**	
Wheezing		**Back pain**	
Abdominal pain		**Skin rash**	
Nausea		**Anxiety**	
Depression			

Please check if you **CURRENTLY** have any of the following Breast Symptoms:

Breast Mass: Yes: ____ No: ____ Right: ____ Left: ____

Breast Pain: Yes: ____ No: ____ Right: ____ Left: ____

Nipple Discharge: Yes: ____ No: ____ Right: ____ Left: ____

Other: _____

Patient Name: _____

GAIL MODEL

Please answer the following questions:

Age:	
Age at first menstrual cycle:	
Age at first live birth:	
Number of first degree relatives with breast cancer:	
Number of previous breast biopsies:	
History of atypical hyperplasia:	**YES NO**
	Circle One Caucasian African American Hispanic Asian/Other

FOR OFFICE USE ONLY: CALCULATED RISK

5 YEAR: _____%

LIFETIME: _____%

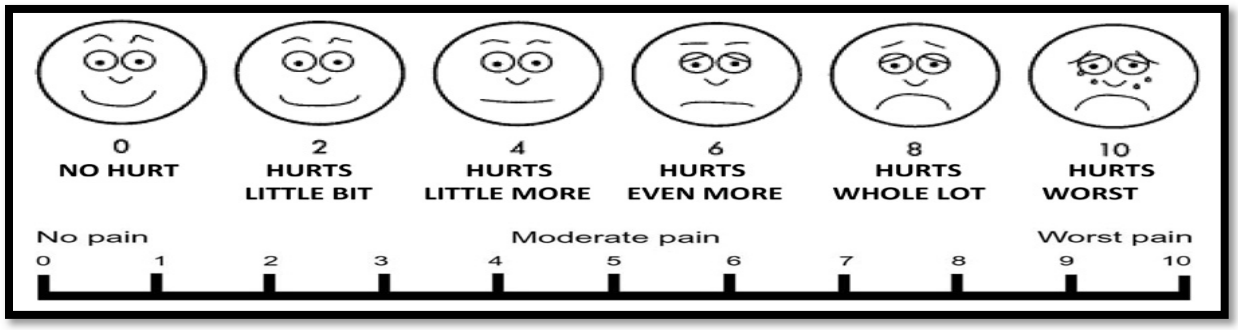
Patient Name: _____

PREVENTATIVE CARE:

	Month/Year
Last Flu Shot	
Last Pneumonia Vaccine	
Last Shingles Vaccine	
Last Colonoscopy	
Last Bone Density Scan	
Last Pap Smear/Pelvic Exam	

On a scale of 0-10 with 10 being the worst, how would you rate your pain level throughout your whole body? _____

Pain Location: _____



Pharmacy Name: _____

Address: _____

Phone: _____

COMPREHENSIVE
CANCER CENTERS

Using and Disclosing Protected Health Information for Involvement in the Individual's Care and Notification Purposes

As per the notice of privacy practices, Comprehensive Cancer Centers must provide the patient with an opportunity to agree or disagree to the use or disclosure of patient health information to a patients' family member, friends or acquaintances involved in their care.

This document will serve as a written agreement between _____ (patient) and Comprehensive Cancer Centers as a list of those designated by the patient as having direct involvement in the patient's care.

In the event you are unable to sign a medical release for your records, please provide us with a list to include your next of kin and/or persons names you will authorize us to release your medical records to. It will be the patient's responsibility to update as necessary.

Next of kin:

Name	Phone	Relationship
_____	_____	_____

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yes / No Per My Permission – Leave medical information on my answering machine.

I hereby authorize Comprehensive Cancer Centers to use or disclose my personal health information to the above mentioned for the purpose of my care or payment related to my care. This information may also be used for the purpose of notifying, or assist in notification of (including identifying or locating), a family member, personal representative or another person responsible for my care, of my location and/or condition.

_____	_____	_____
Patient Signature	SS #	Date

COMPREHENSIVE
CANCER CENTERS

ACKNOWLEDGEMENT OF RECEIPT

OF NOTICE OF PRIVACY PRACTICES

Comprehensive Cancer Centers of Nevada is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Comprehensive Cancer Centers of Nevada.

Date:_____

Name:_____

Siganture:_____

Name of Personal Representative *(if appropriate):* _____

Signature of Personal Representative *(if appropriate):*_____

Comprehensive Cancer Centers of Nevada Use Only

Date acknowledgment received:_____

-OR-

Reason acknowledgment was not obtained: _____

_____

_____

_____

COMPREHENSIVE
CANCER CENTERS

User Electronic Mail Authorization Form
Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. **Please look for an email from My Care Plus promptly after submitting this form**. For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. If you do not have e-mail access, please check the box and sign at the bottom.

_____ _____
Patient Name (First Name, Middle Initial, Last Name) | Date of Birth of Patient

☐ **I do not have e-mail access.** ☐ **I do not want access to the portal.**

Authorized user is:

_____
Authorized User Name (If different from patient)

- ☐ Patient
- ☐ Patient's Guardian (or parent of un-emancipated minor patient)
- ☐ Person authorized to make decisions on behalf of patient (*e.g.* by a medical power of attorney)

_____ _____
Email Address of Patient or Authorized User | Physician's Name

_____ _____
Authorized Signature | Date

_____ _____
Signature of Practice Staff [Confirming user's identity and authority] | Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e., the Authorized User) understands and agrees to use the listed email address for this purpose.

Staff Use Only:	MRN_____
Email in PMS_____	iKM Consent_____

COMPREHENSIVE
CANCER CENTERS

Patient Name: _____ Date: ___/___/_____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize:

_____

_____

To release any and all of my medical records to:

M. Ferra Lin-Duffy, DO, FACOS
Comprehensive Cancer Centers
10001 S. Eastern Avenue, Suite 108
Henderson, NV 89052
Phone: (702) 952-3444; Fax: (702) 565-2021

Print Name: _____

Signature: _____ Date: _____

Date of Birth: _____

PLEASE RELEASE THE FOLLOWING:

_____History & Physical
_____Mammograms
_____Recent Diagnostic Tests
_____Other (see below)
_____All requested (see attached list)

_____Last Progress Notes
_____All Labs
_____Pathology
_____ER, PR & DNA Tests

_____

_____

_____

_____

COMPREHENSIVE
CANCER CENTERS

NOTICE OF PRIVACY PRACTICES

Effective Date: May 1, 2016

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.

About Us

In this Notice, we use terms like "we," "us," "our" or "Practice" to refer to Comprehensive Cancer Centers of Nevada, its physicians, employees, staff and other personnel. All of the sites and locations of Comprehensive Cancer Centers of Nevada follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes and for other purposes as described in this Notice.

Purpose of this Notice

This Notice describes how we may use and disclose your health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities

We are required by law to maintain the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information. We are also required to notify you of a breach of your unsecured health information. We will abide by the terms of this Notice.

How We May Use or Disclose Your Health Information

The following categories describe examples of the way we use and disclose health information without your written authorization:

For Treatment: We may use and disclose your health information to provide you with medical treatment or services. For example, your health information will be shared with your oncology doctor and other health care providers who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your primary care physician or another healthcare provider to be sure they have all the information necessary to diagnose and treat you.

For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. These uses and disclosures are necessary to run the Practice and make sure our patients receive quality care. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities. We may also disclose your health information to third party "business associates" that perform various services on our behalf, such as transcription, billing and

collection services. In these cases, we will enter into a written agreement with the business associate to ensure they protect the privacy of your health information.

Individuals Involved in Your Care or Payment for Your Care and Notification: If you verbally agree to the use or disclosure and in certain other situations, we will make the following uses and disclosures of your health information. We may disclose to your family, friends, and anyone else whom you identify who is involved in your medical care or who helps pay for your care, health information relevant to that person's involvement in your care or paying for your care. We may also make these disclosures after your death.

We may use or disclose your information to notify or assist in notifying a family member, personal representative or any other person responsible for your care regarding your physical location within the Practice, general condition or death. We may also use or disclose your health information to disaster-relief organizations so that your family or other persons responsible for your care can be notified about your condition, status and location.

We are also allowed to the extent permitted by applicable law to use and disclose your health information without your authorization for the following purposes:

As Required by Law: We may use and disclose your health information when required to do so by federal, state or local law.

Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your 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.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement: We may disclose your health information, within limitations, to law enforcement officials for several different purposes:

- To comply with a court order, warrant, subpoena, summons, or other similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime, if the victim agrees or we are unable to obtain the victim's agreement;
- About a death we suspect may have resulted from criminal conduct;
- About criminal conduct we believe in good faith to have occurred on our premises; and
- To report a crime not occurring on our premises, the nature of a crime, the location of a crime, and the i identity, description and location of the individual who committed the crime, in an emergency situation.

Public Health Activities: We may use and disclose your health information for public health activities, including the following:

- To prevent or control disease, injury, or disability;
- To report births or deaths;
- To report child abuse or neglect;
- Activities related to the quality, safety or effectiveness of FDA-regulated products;
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition as authorized by law; and
- To notify an employer of findings concerning work-related illness or injury or general medical surveillance that the employer needs to comply with the law if you are provided notice of such disclosure.

Serious Threat to Health or Safety: If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat or as necessary for law enforcement authorities to identify or apprehend an individual.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle procurement, transplantation or banking of organs, eyes, or tissues.

Coroners, Medical Examiners, and Funeral Directors: We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Workers' Compensation: We may disclose your health information as authorized by and to the extent necessary to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Military and Veterans Activities: If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so they may provide protective services for the President and others, including foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing you health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

Research: We may use and disclose your health information for certain research activities without your written authorization. For example, we might use some of your health information to decide if we have enough patients to conduct a cancer research study. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your health information without your authorization.

Other Uses and Disclosures of Your Health Information that Require Written Authorization:

Other uses and disclosures of your health information not covered by this Notice will be made only with your written authorization. Some examples include:

- Psychotherapy Notes: We usually do not maintain psychotherapy notes about you. If we do, we will only use and disclose them with your written authorization except in limited situations.

- Marketing: We may only use and disclose your health information for marketing purposes with your written authorization. This would include making treatment communications to you when we receive a financial benefit for doing so.

- Sale of Your Health Information: We may sell your health information only with your written authorization.

If you authorize us to use or disclose your health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by your revocation, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health Information

You have the following rights regarding the health information we maintain about you:

Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment or health care operations. **In most circumstances, we are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing and submit it to **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014.** We are required to agree to a request that we restrict a disclosure made to a health plan for payment or health care operations purposes that is not otherwise required by law, if you, or someone other than the health plan on your behalf, paid for the service or item in question out-of-pocket in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014.** We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

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. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014.** You may request access to your medical information in a certain electronic form and format if readily producible or, if not readily producible, in a mutually agreeable electronic form and format. Further, you may request in writing that we transmit a copy of your health information to any person or entity you

designate. Your written, signed request must clearly identify such designated person or entity and where you would like us to send the copy. If you request a copy of your health information, we may charge a cost-based fee for the labor, supplies, and postage required to meet your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014.**

We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us that will become part of your medical record.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures we make of your health information. Please note that certain disclosures need not be included in the accounting we provide to you.

To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014.** Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please alert the receptionist at the front desk of any of our locations or contact **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014.** You may also obtain a paper copy of this Notice at our website, **www.cccnevada.com.**

Changes to this Notice

We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice in the patient waiting areas at each facility. Each version of the Notice will have an effective date listed on the first page. Updates to this Notice are also available at our website, **www.cccnevada.com.**

Complaints

If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to: **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014,** or phone **(702) 952-3350.** You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against or penalized for filing a complaint.

Questions

If you have questions about this Notice, please contact **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014,** or phone **(702) 952-3350.**