THE Breast CENTER
Specialists In Breast Care

Chart #

Office Use Only

PATIENT INFORMATION			
Last Name	First Name		Middle Initial
Your Name as it appears on your insurance card			
Street Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Best place and time to contact you:	Can we leave a message at home: ☐Y or ☐N Can we leave a message at work: ☐Y or ☐N		
SSN	Date of Birth	☐ Male ☐ Female	Marital Status
Race	Ethinicity		Preferred Language
Employer Name and Address	Email		
Primary Care Physician *(name and phone number)* Referring? Yes / No	OB/GYN *(name and phone number)* Referring? Yes / No		
Emergency Contact	Emergency Contact's Phone #	Relationship to Emergency Contact	

Insurance Policy Holder (Sponsor's Information, leave blank if same as above)			
Last Name	First Name		Middle Initial
SS #	Date of Birth	☐ Male ☐ Female	Relationship to insured
Street Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Employer Name and Address			

Insurance Information		
Primary Insurance Company	Policy Number	Group Number
Secondary Insurance Company	Policy Number	Group Number

When checking in, the receptionist will need your insurance card(s), a picture ID, and your co-pay amount.

We will file insurance with your provider according to your individual plan.

Our fees will vary depending on the complexity of your problem and the service provided. We will be glad to discuss our fees with you at any time. If payment of charges imposes a financial burden, we ask that you speak to our billing office for specific payment arrangements prior to your appointment. We will make every effort to assist you with your needs.

Patient / Guardian Signature

Date

The Breast Center, P.C.

Financial Policy

Your clear understanding of our Financial Policy is important to us. **Please read carefully.** If you have any questions or concerns regarding the Financial Policy, please do not hesitate to speak to someone in our billing office.

The Breast Center accepts **most** insurance plans, but it is the patient's responsibility to confirm our participation with either our office or your insurance company.

All Patients:

- The patient is primarily responsible for all charges incurred for services and procedures rendered at The Breast Center.
- We accept cash, checks, money orders, American Express, Visa, MasterCard and Discover.
- A returned check fee of $35.00 will be assessed on any and all returned checks.
- Delinquent accounts over 90 days will be referred to our collection agency. All costs of collection is the liability of the patient.
- Accounts carrying a balance over 90 days will be transferred to our agency and payment arrangements can be made with them.
- Depending on your services you may receive statements from The Breast Center, WellStar and/or Quantum Radiology.
- Fees for surgical procedures will vary depending on the service(s) provided. We will assist you in pre-certifications if required. Any deductible or co-insurance amount that is the patient's responsibility will be due prior to surgery.
- If the patient does not speak English, it is their responsibility to obtain an interpreter to assist in completing and understanding any documents. This person must be age 18 or older.

Uninsured Patients:

- Uninsured patients are expected to pay for services in advance unless prior arrangements are made. Please do not hesitate to ask what the fees are for any services. If payment of charges imposes a financial burden, please speak to the billing office to set up a specific payment arrangement. We will make every effort to assist you with your needs.

Surgical Patients:

- All procedures cancelled or rescheduled within 3 days of the surgery date will be charged a $150.00 non-refundable administration fee. This fee will be waived if it is cancelled by a physician.

Medicare Patients:

- All physicians at The Breast Center are providers for Medicare. We will submit claims to Medicare and any supplemental insurance you have. Any remaining balance is the patient's responsibility after payment from insurance and contract adjustments have been made.

Medicaid Patients:

- All Medicaid patients are required to present a current Medicaid card at every visit. If your Medicaid plan changes, it is your responsibility to make sure The Breast Center has the correct information for billing purposes. If your claim is denied, you are responsible for the fees incurred.

Initial _____

Insured Patients:

- It is the patient's responsibility to know and understand their insurance plan. This includes the financial responsibility for services rendered such as co-pays, deductibles, co-insurance and anything else that your plan determines is patient responsibility. We are required to collect co-pays, deductibles and co-insurance per our contracts with insurance carriers. These amounts cannot be negotiated or waived.
- The patient is required to provide the most current insurance information, including a copy of the insurance card and any changes in the insurance plan coverage.
- The patient is responsible for any services and/or procedures not covered by their insurance plan.
- The patient must obtain proper referral and/or authorization if required by their insurance plan prior to the appointment to avoid being held responsible for any charges incurred.
- The Breast Center allows 60 days from the date the claim is filed for insurance to pay. It is the patient's responsibility to ensure their insurance plan pays in a timely manner. If no payment has been received from the insurance company after the 60 day grace period, the patient will be billed for the balance.

_____
Print Name

_____
Signature

_____
Date

Name of Patient if Signed by Legal Guardian: _____

The Breast Center, P.C.

Consent and Release

The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows:

- Patient or legal custodian authorized the Staff Physician(s) or Nurse Practitioner to examine and treat the patient.
- The Breast Center is granted permission to release to the insurance carriers, referring physician and primary care physician any information deemed necessary, as may be requested, relating to any treatment rendered to patient.
- Patient or legal custodian shall agree to pay to The Breast Center such sums as are, or may become, due for services rendered to the patient. All co-pays and deductibles are due and payable at the time of service.

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to me directly to The Breast Center. I hereby authorize The Breast Center to release any information necessary to process my claim. I understand that I am legally and financially responsible for all charges not covered by my insurance plan. I hereby authorize payment directly to The Breast Center for services rendered.

I understand if my insurance plan sends me a check for payment of the medical services provided by The Breast Center, the check belongs to The Breast Center and I must immediately deliver the check to The Breast Center for payment on my account.

In the event that my insurance plan denies my claim and I choose to appeal their decision, this form and my signature authorizes The Breast Center to submit an appeal along with any necessary medical information to my insurance plan.

_____

Print Name

_____

Signature

_____

Date

Name of Patient if Signed by Legal Guardian: _____

Revised 06/23/2014

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CONSENT AND RELEASE

1. The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows:
2. Patient or legal custodian authorized the Staff Physician(s) or Nurse Practitioner to examine and treat the above patient
3. The Breast Center is granted permission to release to the insurance carriers, referring physician and primary care physician any information deemed necessary, as may be requested, relating to any treatment rendered to patient.
4. Patient or legal custodian shall agree to pay to The Breast Center such sums as are, or may become, due for services rendered to the patient. All co-pays and deductibles being due and payable at the time of service.
5. In the event that the patient's insurance company does not make full payment on this obligation, all balances will be due and immediately payable by the patient and /or legal guardian.
6. A returned check fee of $35 will be assessed on any and all returned checks.
7. Delinquent accounts will be assessed all collection, legal, and administrative costs to the fullest extent of the law.
8. Patient or legal guardian understands that if their insurance company requires that a referral be issued, it must be received at the time of service. If seen without a valid referral the patient accepts responsibility for full payment at the time of service with the understanding that no claim will be filed with the insurance carrier.
9. Our fees for surgical procedures will vary depending on the complexity of your problem and the service provided. If the surgical procedure is performed outside of our facility, we will assist you in pre-certification, second opinion, etc. We will ask for the patient's portion of the surgical bill prior to surgery (outstanding deductible and / or copay). You will receive separate bills from the surgery facility, lab, etc.
10. If payment of charges imposes a financial burden, we ask that you speak to the account manager for specific payment arrangements. We will make every effort to assist you with your needs.

INSURANCE PAYMENT PLAN

We will file insurance with your provider according to your individual plan. The patient will be responsible for any outstanding deductible, their 20% and/or co-pay. Referral numbers required by some insurance companies must be given at the time of service, otherwise the service becomesthe patient's responsibility. For all private insurance companies, the patient will be responsible for payment at time of service. We will provide the necessary information for the patient to file for reimbursement.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment directly to the physician of the surgical and/or medical benefits, otherwise payable to me for services as described, realizing that I am responsible to pay for non-covered services.

Patient / Guardian Signature _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the physician to release any information required in the course of my treatment necessary to process insurance claims.

Patient / Guardian Signature _____ Date _____

THE Breast CENTER
Specialists In Breast Care

1790 Mulkey Road, Ste. 9C, Austell, GA 30106
6002 Professional Pkwy., Ste. 260, Douglasville, GA 30134
702 Canton Road, Marietta, GA 30060
699 Church Street, Suite 210, Marietta, GA 30060

PRIVACY PROTECTION NOTICE

I have received and understand the "Notice of Privacy Protection Practices" from The Breast Center.

_____ _____

(Signature) *(Date)*

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

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.

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

The following paragraphs describe different ways that we 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. 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 another physician who we have requested to be involved in your care. *For example* – we would 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.

Other Ways 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 to 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 health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

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 illness.

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 practice administrator, at The Breast Center, 702 Canton Rd., Marietta, GA 30060. 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 our practice 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 practice 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 regulation) 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 where 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 manager, 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 The Breast Center, 702 Canton Rd., Marietta, GA 30060. 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.

For More Information

If you have questions or would like additional information, please contact the practice administrator at (770) 428-4486 x 103.

RELEASE OF PATIENT INFORMATION

I authorize The Breast Center to release information concerning my care to the following family members or associates.

_____ Relationship: _____

THE Breast CENTER
Specialists In Breast Care

LAST NAME: _____ **FIRST:** _____ **MI:** _____

DATE: _____ **DOB:** _____ **ACCT #:** _____

REASON FOR OFFICE VISIT:

Which doctor referred you today? _____

Are you a new patient to The Breast Center?	Y	N	
Is this a follow up exam?	Y	N	
Do you feel a new breast lump?	Y	N	If yes, which breast and for how long?_____
Do you have an abnormal mammogram?	Y	N	
Do you have nipple discharge?	Y	N	If yes, which breast and color of discharge?_____
Do you have breast pain?	Y	N	If yes, which breast and for how long?_____
Do you have skin changes?	Y	N	If yes, which breast and describe?_____

PAST MEDICAL HISTORY:

Do **you** have a history of breast cancer?	Y	N	
If yes, which breast?	R	L	Lumpectomy or mastectomy?_____
Radiation therapy?	Y	N	
Chemotherapy?	Y	N	
Antiestrogen medications?	Y	N	If yes, list (Tamoxifen, Arimidex, etc)_____
Do **you** have a history of ovarian cancer?	Y	N	
Do **you** have a history of any other cancers?	Y	N	If yes, list _____
Do **you** have a history of mastitis/breast infections?	Y	N	
Do **you** have a history of breast injuries or trauma?	Y	N	
Do **you** have a history of breast cysts?	Y	N	
Are **you** taking hormones (estrogen,progesterone)?	Y	N	If yes, list _____
Are **you** taking Birth Control Pills?	Y	N	

SOCIAL HISTORY:

Do you smoke?	Y	N	If so, how many per day? _____
Did you smoke in the past?	Y	N	How long ago did you quit? _____
Do you drink alcohol?	Y	N	How often? _____
Do you drink caffeine?	Y	N	How often? _____
Do you exercise?	Y	N	How often? _____

REPRODUCTIVE HISTORY:

Age of 1st menstrual cycle	_____		
Age of 1st pregnancy	_____		
Age of menopause	_____		
Date of your last pap smear	_____		
Are **you** pregnant?	Y	N	If yes, due date _____
Are **you** breast feeding?	Y	N	

THE Breast CENTER
Specialists In Breast Care

LAST NAME: _____ **FIRST:** _____ **MI:**_____

DATE: _____ **DOB:** _____ **ACCT #:** _____

FAMILY HISTORY:
List any family members that have the following medical conditions:

High Blood Pressure _____ Heart Attack _____Heart Failure _____
Stroke _____Diabetes _____

Family members with **Breast Cancer**? - Y N (if yes, list age at diagnosis)

First Degree relatives: Mother _____ Sister(s) _____ Daughter(s) _____

Mother's Side: Grandmother _____Aunt(s) _____Cousin(s) _____Men_____

Father's Side: Grandmother _____Aunt(s) _____Cousin(s) _____Men _____

Family members with **Ovarian cancer**? Y N please list_____
Uterine cancer? Y N _____
Prostate cancer? Y N _____
Pancreatic cancer? Y N _____

YOUR PAST SURGICAL HISTORY:
Name and dates of operations and/or Biopsies:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

METALIC IMPLANTS:
Do you have any of the following:

Pacemaker	Y	N
Stimulator	Y	N
Stent	Y	N
Aneurysm Clip	Y	N

THE Breast CENTER
Specialists In Breast Care

LAST NAME: _____ **FIRST:** _____ **MI:** _____

DATE: _____ **DOB:** _____ **ACCT #:** _____

HEALTH INFORMATION - Circle Yes or No

General
Weight loss Y N
Weight gain Y N
Current weight _____
Current height _____

Other skin symptoms
Skin problems Y N
Rashes Y N
Other: _____

Ear, Nose and Throat
Earache Y N
Hearing Loss Y N
Nose bleeds Y N
Nasal discharge Y N
Mouth sores Y N
Throat pain Y N
Other: _____

Heart
Rapid heartbeat Y N
High blood pressure Y N
Are you taking blood thinners? Y N
Other: _____

Lung symptoms
Asthma (wheezing) Y N
Other: _____

Endocrine symptoms
Thyroid Disorders Y N
Diabetes Y N
Other: _____

Infectious Diseases
HIV/ AIDS Y N
Hepatitis B Y N
Hepatitis C Y N

Bone and Joint symptoms
Joint pain Y N
Muscle Aches Y N

Neurological
Difficulty moving arms/legs Y N
Fainting Y N
Headaches Y N
Do you use a cane, walker, or wheelchair Y N
*if so, do you have frequent falls Y N

Lymphatic symptoms
Neck pain Y N
Lump in neck Y N
Lump in armpit Y N
Other: _____

Gastrointestinal symptoms
Decreased appetite Y N
Heartburn Y N
Other: _____

Bleeding disorders
Do you have any bleeding problems? Y N
Do you tend to bruise easily Y N
Other: _____

Psychological symptoms
Sleep disturbances Y N
Anxiety Y N
Depression Y N
Other: _____

THE Breast CENTER
Specialists In Breast Care

LAST NAME: _____ **FIRST:** _____ **MI:** _____

DATE: _____ **DOB:** _____ **ACCT #:** _____

ALLERGIES:

*No known or list below

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Are you allergic to IV Contrast? Yes No

MEDICATIONS:

Please list dosage and frequency

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

General Breast Health Questions

Y N Have you been instructed to perform breast self examinations?
Y N Do you examine your breasts monthly?
Y N Have you ever had a breast mammogram? If so, when was your last mammogram prior to today?
Y N Do you understand that it is recommended to have a yearly breast examination by a health care provider?
Y N Do you understand that very tiny breast cancers may not be felt by your doctor and that is why repeat examinations are necessary?
Y N Do you understand that mammograms are very helpful, but that not all breast cancers can be seen on x-ray or ultrasound?

☐ Please check if you have had any changes in your health in the past year.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____