

**REVIEW OF SYSTEM**

**MEDICATIONS**

This is very important. Please list or obtain a list of all medicines you are taking with the exact dose and schedule:

Medication	Dosage	Schedule (taken how often?)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies to any drugs or medical products? **Yes** **No** If yes, please list:  
 \_\_\_\_\_  
 \_\_\_\_\_

**PLEASE CIRCLE ANY SYMPTOMS YOU ARE HAVING AND ELABORATE AS NEEDED:**

**CONSTITUTION**

Fever or chills  
 Weight loss

**ENT**

Cough  
 Cold  
 Sinus infection

**CARDIOVASCULAR**

Shortness of breath or decreased exercise tolerance  
 If yes, how may flights of stairs can you climb without stopping \_\_\_\_\_  
 Heart problems  
 Hearth attack  
 Valve problems  
 Blood clots anywhere  
 Rheumatic fever  
 Take antibiotics before dental procedures  
 Abnormal heart rhythm  
 Take Digoxin  
 High blood pressure

**GASTROINTESTINAL / RENAL**

Liver problems  
 Gallstones  
 Jaundice  
 Hepatitis  
 Stomach ulcer or peptic ulcer  
 Colon cancer  
 Alcohol consumption  
 If yes, how much per week \_\_\_\_\_  
 How long \_\_\_\_\_  
 Skin problems  
 Renal or kidney problems?  
 Kidney failure / dialysis  
 Recurrent burning on urination or infections

**PULMONARY**

Pneumonia  
 Emphysema  
 Asthma  
 Wheezing  
 Shortness of Breath  
 Lung operations  
 Lung problems  
 Tuberculosis  
 Smoking of tobacco or other substances  
 How Long? \_\_\_\_\_  
 How many packs per day? \_\_\_\_\_

**NEUROLOGIC**

Numbness – Location: \_\_\_\_\_  
 Tingling – Location: \_\_\_\_\_  
 Stroke  
 Weakness of extremity  
 Epilepsy or seizures  
 Other

**ENDOCRINE**

Thyroid problems  
 Diabetes  
 Steroid Usage  
 Other

**BLOOD/LYMPHATICS**

Hemophilia  
 Blood clots – Location: \_\_\_\_\_  
 Bleeding problems  
 Aspirin usage more than once a week  
 Use of blood thinners such as Coumadin  
 Anemia  
 Enlarged lymph nodes  
 Lymphedema

**For Office Use Only: Health Survey Form Updates**

Date	Initials	Date	Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**FAMILY HISTORY** (First degree relatives)

Heart disease  
 High blood pressure  
 Diabetes  
 Problems with anesthesia  
 Cancer

# PATIENT AUTHORIZATION FOR USE BY BREAST CARE SPECIALISTS AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

By signing, I authorize **BREAST CARE SPECIALISTS, LLC** to use and/or disclose certain protected health information (PHI) about me to (please list your referring physician(s) and or any other physician that you would like to receive a copy of your medical record (PHI) generated as part of your establishment as a patient of **BREAST CARE SPECIALISTS, LLC**. *Failure to authorize release of PHI may prevent the exchange of vital information associated with care delivery.*

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

This authorization permits **BREAST CARE SPECIALISTS, LLC** to use and/or disclose the following individually identifiable health information about me (please check all that apply – if unsure, please check all boxes)

- |                                                                   |                                            |
|-------------------------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Office Notes (office visit MD notations) | <input type="checkbox"/> Mammogram Reports |
| <input type="checkbox"/> Ultrasound Reports                       | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Other _____                              |                                            |

The information will be used or disclosed for the following purpose: (please check)

- |                                                        |
|--------------------------------------------------------|
| <input type="checkbox"/> At the request of the patient |
| <input type="checkbox"/> Other _____                   |

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. The practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI, only in some cases a fee for the copying of the information.

- ✓ I hereby give my consent for BREAST CARE SPECIALISTS, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by BREAST CARE SPECIALISTS, LLC describes such uses and disclosures more completely.) Without consent, PHI will not be disclosed and may delay patient-requested activity.
- ✓ I have the right to review the Notice of Privacy Practices prior to signing this consent. BREAST CARE SPECIALISTS, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, 975 Johnson Ferry Rd, Suite 500, Atlanta, GA 30342.
- ✓ With this consent, BREAST CARE SPECIALISTS, LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.
- ✓ With this consent, BREAST CARE SPECIALISTS, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

*By signing this form, I am consenting to allow BREAST CARE SPECIALISTS, LLC to use and disclose my PHI to carry out TPO. I do not have to sign this authorization in order to receive treatment from BREAST CARE SPECIALISTS, LLC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: Breast Care Specialists, LLC*

Signed by: \_\_\_\_\_  
Signature of Patient or Legal Guardian      Date      Relationship to Patient

\_\_\_\_\_  
Print Patient's Name      \_\_\_\_\_  
Print Name of Legal Guardian, if applicable

# BREAST CARE SPECIALISTS, L.L.C.

*A multidisciplinary approach to Breast Health*

## PATIENT INFORMATION

SS#	Last Name	First Name	MI
Address		Nickname	
City	State	Zip	
Home Phone	Cell Phone		
Date of Birth	Sex	Race	
Marital Status (S,M,D,W)		E-mail Address	
Employer Name		Business Phone	
Business Address			
Referring Physician		Referring Physician Phone	
Relative / friend not living with you	Relative / friend phone		Relationship

## INSURED INFORMATION

SS#	Last Name	First Name	MI
Address			
City	State	Zip	
Home Phone	Date of Birth		
Employer Name	Address		

## INSURANCE INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE	
Insurance Name	Phone	Insurance Name	Phone
Insurance Address		Insurance Address	
ID#	Group#	ID#	Group#
Policy Holder Name	Patient Relationship to Insured	Policy Holder Name	Patient Relationship to Insured
Address if different from patient		Address if different from patient	
Home Phone	Employer Phone	Home Phone	Employer Phone

I authorize examination and treatment by the physicians of Breast Care Specialists, LLC. I understand that payment is due at the time services are rendered unless I participate in an insurance plan that is contracted with this practice. I understand that I am responsible for co-payment, co-insurance and deductible, if any. I understand that I am responsible for obtaining referrals required by my insurance plan, and that I am financially responsible for all services rendered without a referral. I understand that if my insurance does not cover the services that I receive, final responsibility for my bill belongs to me. I hereby authorize payment of insurance benefits to Breast Care Specialists, LLC. I further authorize the release of medial information necessary to process my insurance claims.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

## Our Financial Policy

*We are committed to providing you with the best possible care and we are please to discuss our financial policy at any time. Please ask us if you have any questions about our financial policy or your financial responsibility.*

All new patients are asked to complete a Patient Information Form prior to being seen by the provider. We ask that you complete all of the information including your insurance information. We also ask to make a copy of a picture ID and your insurance care to remain a permanent part of your chart.

### INSURANCE COVERAGE & PATIENT RESPONSIBILITY

**You are responsible for the payment of co-payment, co-insurance, non-covered services, or any patient responsible balance at the time of service. If you are covered by a plan in which we participate as a provider, we will file your insurance claim. In the event your insurance company does not pay the full balance, we will notify you so that you may contact your insurance carrier or resolve your account. Please remember payment responsibility rests with the patient, if no coverage exists for services performed.**

- **All non-covered patients are expected to pay for services in full at the time the services are rendered.**
- **Please advise the office personnel of any changes in your insurance or mailing address.**
- **Payment arrangement can be negotiated prior to services being rendered. Please ask for assistance, if required.**

Should it ever become necessary to use the services of an outside collection agency to collect your account, you could be responsible for any costs incurred for that purpose.

**REFERRALS:** If your visit requires a referral from a primary care provider, we will alert you via phone prior to your visit and offer our assistance. **IF YOU DID NOT HAVE A REFERRAL FOR TODAY'S VISIT...** you should reschedule immediately. Should you choose to be seen without a referral, you understand that the charges incurred may be uncovered and that any diagnosis resulting from the encounter may also be uncovered and may prevent future services from coverage (i.e. surgery).

**ASSIGNMENT OF BENEFITS:** I hereby authorize Breast Care Specialists, LLC to bill my insurance company directly for the services rendered. I understand that I am financially responsible for charges not covered by my insurance company. I authorize any holder of medical or other information about me to release to the Social Security Administration, intermediaries, other providers of treatment or procedures, or intermediaries needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request for payment of medical benefits to myself or to the party who accepts assignment of benefits.

**WORKER'S COMPENSATION:** Worker's compensation patients will be seen only after the proper authorization and documentation has been received.

**UNACCOMPANIED MINORS:** The parents or guardians will be responsible for the full payment unless covered by a participating managed care plan. Authorization to treat an unaccompanied minor must be on file.

**METHODS OF PAYMENT:** CASH, CHECK, VISA, MASTERCARD AND DISCOVER are all accepted. We also offer automatic debit for patient responsible balances.

We thank you for carefully reading this financial policy. We trust that you understand its contents. If you have any questions, please feel free to ask. Please sign below to indicate your understanding and acknowledgment of this policy.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Patient's Name (Please print)

\_\_\_\_\_  
Date

## Summary of Privacy Notice

---

**THIS NOTICE DESCRIBES HOW HEALTH 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 HEALTH INFORMATION IS IMPORTANT TO US.**

---

### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or additional copies of this Notice, please contact us using the information listed at the end of this Notice.

---

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved in Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses and disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

**Marketing Health-Related Services:** We will not share your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstance. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters.)

---

## **PATIENT RIGHTS**

**Access:** You have the right to inspect and obtain a copy of your protected health information, with limited exceptions. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us as a result of complying with your request. Requests for access to your protected health information must be made in writing.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six years, but not before April 14, 2003. You must make your request in writing. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). You must make your request in writing.

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide a satisfactory explanation of how payments will be handled under the alternative means location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Right to Express Complaints:** You have the right to express complaints to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. If you wish to complain to us, you must do so in writing, and direct your complaint to the Privacy Leader.

You have the right to Obtain a Paper Copy of this Privacy Summary Notice as well as the full Privacy Notice.

---

### **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices, or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. You will not be penalized in any way if you choose to file a complaint with us and/or with the U.S. Department of Health and Human Services.

Contact Officer: Office Manager/Privacy Leader

## Privacy Notice Acknowledgement

I acknowledge that I have received a copy of the Summary Privacy Notice for Privacy Notice  
revision Date: April 14, 2003

\_\_\_\_\_  
Patient or Personal Representative's Name Printed    Patient or Personal Representative's Signature    Pt's Date of Birth

\_\_\_\_\_  
Personal Representative's Relation to Patient    Date

---

### Documentation of Good Faith Effort

The patient identified above was provided with a copy of the Provider's Summary Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgment of the patient's receipt of the Summary Privacy Notice. However, acknowledgement has not been obtained because:

\_\_\_ Patient refused to sign the Summary Privacy Notice Acknowledgement

\_\_\_ Patient was unable because:

\_\_\_\_\_

\_\_\_ There was a medical emergency. Provider will attempt to obtain  
acknowledgement as soon as practical.

\_\_\_ Other reason, describe below: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Employee's Name Printed

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date