Name _____ Date of Birth _____ Today's Date _____ Page ____

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

For Office Use Only: Health Survey Form Updates

Date	Initials	Date	Initials

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

FAMILY HISTORY (First degree relatives)
Heart disease
High blood pressure
Diabetes
Problems with anesthesia
Cancer

Breast Care Specialists

PLEASE BE ADVISED: We are a diagnostic facility that specializes in breast care. Your Insurance plan may not cover a diagnostic mammogram at 100% as it does for a screening mammogram. Please check with your insurance company if you have questions about your coverage for diagnostic services.
_____(Please Initial)

PATIENT INFORMATION

Name:	Email Address:
c/o (if a minor):	Cell Phone#:
Address 1:	Home Phone#:
Address 2:	Work Phone#:
City:	Employer:
State: Zip:	Emergency Contact:
Date of Birth:	Emergency Phone#:
Sex (circle one): M F Marital Status (circle one): M S D W	Emergency Relationship:

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
ID Number:	ID Number:
Group Number:	Group Number:
Group Name:	Group Name:
Subscriber Name:	Subscriber Name:
Subscriber Date of Birth:	Subscriber Date of Birth:

REFERRAL INFORMATION

Referred by Doctor (First and last name):	Referred by Other (family,friend,etc):
Phone Number:	
Does your insurance require an authorization # from your primary care physician? Yes or No	
Primary Care Physician:	
Phone Number:	

I acknowledge that the physicians of BCS may not be a part of the provider network for my insurance plan. I understand it is my responsibility to verify this information with my insurance company. I also acknowledge it is my responsibility to obtain an authorization number from my primary care physician if required by my insurance plan.

Unless prior arrangements have been made with our business office, payment for services rendered are due at the time of service.

I hereby authorize the physicians of BCS to furnish the necessary information concerning my illness to my insurance company and I hereby assign to the physicians, all payments for medical services rendered to myself or my dependents. I understand I am responsible for obtaining my coverage information from my insurance plan and I also understand I am responsible for any amount not covered by my insurance.

Your signature serves as notice to treat a child if the patient is a minor.

Date:_____Signature:_____Relationship:_____

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)

- ☐ **Office Notes (office visit MD notations)**
- ☐ **Ultrasound Reports**
- ☐ Other _____
- ☐ **Mammogram Reports**
- ☐ **Pathology Reports**

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

- ☐ **At the request of the patient**
- ☐ 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

Elizabeth P. Steinhaus, M.D., F.A.C.S. Diplomate American Board of Surgery

Jennifer L. Amerson, M.D., F.A.C.S. Diplomate American Board of Surgery

Brenda B. Simpson, M.D., F.A.C.S. Diplomate American Board of Surgery

Pamela M. Donlan, M.D. Diplomate American Board of Radiology

Susan A. Mulligan, M.D. Diplomate American Board of Radiology

Carrie L. Stallings, M.D. Diplomate American Board of Surgery

Courtney E. Stewart, M.D. Diplomate American Board of Radiology

Meredith H. Redden, M.D. Diplomate American Board of Surgery

Privacy Notice Acknowledgement

I acknowledge that I have received a copy of the Summary Privacy Notice revision date September 23, 2013.

_____ _____ _____

Patient or Personal Representative's Signature | Patient or Personal Representative's Name Printed | Patient'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 acknowledgement of the patient's receipt of Summary Privacy Notice. However, acknowledgement has not been obtained because

___Patient refused to sign the Summary Privacy notice Acknowledgement

___Patient was unable to sign because _____

___ There was a Medical Emergency. Provider will attempt to obtain acknowledgement as soon as is practical.

___ Other reason: _____

_____

_____ _____ _____

Employee's Name | Employee's Signature | Date

Authorization of Discuss Medical Care

I hereby authorize Breast Care Specialists, LLC to discuss any of my medical care needs (including appointments, results, continuing care, treatments, etc.) with the following people:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

_____ _____

Patient or Personal Representative's Signature | Date

Our Financial Policy

We are committed to providing you with the best possible care and we are pleased 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 will also ask to make a copy of a picture i.d. and your insurance card to remain a permanent part of your chart.

INSURANCE COVERAGE & PATIENT RESPONSIBILITY

You are responsible for co-payments, 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 to resolve your account. Be advised that some insurance companies treat coverage for diagnostic imaging differently than screening imaging and it may be subject to your plan deductible. Please refer to your specific plan document and coverages for your benefits. 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 services are rendered.**
- **Please advise the office personnel of any changes in your insurance or mailing address.**
- **Payment arrangements 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 DO 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 either to myself or to the party who accepts assignment of benefits.

WORKERS COMPENSATION

Worker's compensation patient 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.

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 Name (Please Print)	Date

BCS

METHODS OF PAYMENT

CASH, CHECKS, VISA, MASTERCARD, AMEX AND DISCOVER are all accepted. We also offer automatic debit for patient responsible balances.

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

BCS does not accept the following insurance plans:

Market Place Plans (aka: pathway-obama care-aca-affordable care act-healthcare exchange plans)
Alliant
Ambetter
BCBS (pathway is usally on the card)
Kaiser

Participating Plans

	REFERRAL NEEDED	
	YES	NO
AARP		X
ACS BENEFIT SERVICES		X
AETNA- ALL PLANS		X
AIM		X
AMERICAN MEDICAL		X
ASSURANT		X
BANKERS FIDELITY		X
BCBS-ALL PLANS EXCEPT PATHWAY	GATEKEEPER HMO AND POS REQUIRE A REFERRAL	
CIGNA		X
CIGNA HEALTH SPRINGS(MCARE REPL PLAN)	X	
CORESOURCE		X
COVENANT ADMINISTRATORS		X
COVENTRY/AETNA		X
FEDERATED HEALTH		X
FIRST HEALTH		X
GEHA		X
GOLDEN RULE		X
GREAT WEST/CIGNA		X
GUARDIAN		X
HEALTH PARTNERS		X
HUMANA		X
HUMANA GOLD PLUS(MCARE REPL PLAN)		X
KAISER-ONLY IF PART OF PHCS (AND NOT THE MARKET PLACE PLAN)		X
MEDICAL MUTUAL		X
MEDICARE		X
MERITAIN		X
MHBP(MAIL HANDLERS BENEFIT PLAN)		X
MULTIPLAN		X
NOVA NET		X
PHCS		X
PRINCIPAL		X
PRIORITY HEALTH		X
TRICARE		X
UHC-ALL PLANS	COMPASS AND NAVIGATE PLANS REQUIRE A REFERRAL	
UMR-UNITED MEDICAL RESOURCES		X
USAA		X