

**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 the physicians listed below 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	Fax
Referring Physician: _____			
_____			
Primary Care (Internist, Family Doctor): _____			
_____			
OB/GYN: _____			
_____			
Other: _____			
_____			

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)

**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. This authorization will automatically renew. 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 redisclosure 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*

Jennifer L. Amerson, M.D.

Meredith H. Redden, M.D.

Brenda B. Simpson, M.D.

Carrie L. Stallings, MD.

Diplomate American Board of Surgery

Diplomate American Board of Surgery

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Diplomate American Board of Surgery

Pamela M. Donlan, MD.

Deborah A. Cunningham, M.D.

Kelly C. Starkey, M.D.

Diplomate American Board of Radiology

Diplomate American Board of Radiology

Diplomate American Board of Radiology

## 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



### METHODS OF PAYMENT

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

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## SCREENING MAMMOGRAM VS. DIAGNOSTIC MAMMOGRAM

While the technology is basically the same there are a few key differences between screening and diagnostic mammograms that you should know:

- ☉ Screening mammograms are allowed and for by insurance once a year.
- ☉ A radiologist (physician) does not need to be present for a screening mammogram: whereas the interpreting radiologist is present to review the diagnostic mammogram
- ☉ Diagnostic mammograms take longer than screening mammograms since the radiologist reviews the images while you are in the office. The radiologist may ask the technologist to take more images of the breasts to evaluate areas of concern.
- ☉ In addition to the regular 2D mammogram, the 2D/3D combination tomosynthesis mammogram takes multiple images of breast tissue to recreate a picture of the breast (please see the attached information from the American College of Radiology)

\*\*\*\*\*PLEASE INITIAL\*\*\*\*\*

\_\_\_\_\_ I understand that may be receiving a diagnostic 2D or a diagnostic 2D/3D combination tomosynthesis mammogram today based on what was ordered by my physician. It is not a screening mammogram.

\_\_\_\_\_ I understand that my service may be applied to my deductible and/or co-pay with my insurance plan.

\_\_\_\_\_ I understand that I should consult with my insurance regarding coverage of this service should any questions arise.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## 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: \_\_\_\_\_



# Breast Care Specialists

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Reason for visit: Please mark all that apply.** \_\_\_\_\_ Self-Referred \_\_\_\_\_ Physician Referral

\_\_\_\_\_ Routine visit. I have no changes on my self-breast exam.

\_\_\_\_\_ **New Problem.** Please detail in section C.

\_\_\_\_\_ Abnormal imaging. Please check all that apply:

- \_\_\_\_\_ Abnormal Mammogram
- \_\_\_\_\_ Abnormal Ultrasound
- \_\_\_\_\_ Other (please detail): \_\_\_\_\_
- \_\_\_\_\_ Abnormal CT or MRI
- \_\_\_\_\_ Abnormal PET scan

\_\_\_\_\_ Follow up visit. I have no new changes since my prior visit.

\_\_\_\_\_ Other. Please explain: \_\_\_\_\_

### Section B:

\_\_\_\_\_ YES \_\_\_\_\_ NO Have there been any surgical changes since your last visit?

- \_\_\_\_\_ No change
- \_\_\_\_\_ Reduction
- \_\_\_\_\_ Implants Please detail: \_\_\_\_\_
- \_\_\_\_\_ Fat Injections
- \_\_\_\_\_ Lumpectomy
- \_\_\_\_\_ Excisional Biopsy
- \_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ YES \_\_\_\_\_ NO Have there been any updates to personal or family history of breast or ovarian cancer?  
Please Detail: \_\_\_\_\_

\_\_\_\_\_ YES \_\_\_\_\_ NO Have there been any updates to your genetic testing?  
If so when? Where? \_\_\_\_\_

\_\_\_\_\_ YES \_\_\_\_\_ NO Have you had a recent vaccine (last 3 months)?  
If so which arm and approximate date. \_\_\_\_\_

\_\_\_\_\_ YES \_\_\_\_\_ NO Are you pregnant?

\_\_\_\_\_ YES \_\_\_\_\_ NO Are you lactating?

\_\_\_\_\_ Pre \_\_\_\_\_ Peri \_\_\_\_\_ Post What is your menopausal status?

\_\_\_\_\_ YES \_\_\_\_\_ NO Are there any changes to personal medical History?  
If yes, please detail: \_\_\_\_\_

\_\_\_\_\_ YES \_\_\_\_\_ NO Are there any changes to your personal or family history of cancer?  
If yes, please detail: \_\_\_\_\_

Other updates to family history: \_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_

**Please answer the following questions:**

\_\_\_ YES \_\_\_ NO Are you of Ashkenazi descent?

\_\_\_ YES \_\_\_ NO Do you take any form of Hormone Replacement Treatment?

**A Separate Medication list printout has been provided.**

\_\_\_ YES \_\_\_ NO Did you make any changes to your listed medications?  
If there has been any change of allergies to drugs or medical products.  
Please List. \_\_\_\_\_

\_\_\_ YES \_\_\_ NO Do you consume alcohol?  
IF Yes, How much per week? \_\_\_\_\_  
How Long? \_\_\_\_\_

\_\_\_ YES \_\_\_ NO Do you smoke or use tobacco?  
IF Yes, How much per week? \_\_\_\_\_  
How Long? \_\_\_\_\_

\_\_\_ YES \_\_\_ NO Have you been tested for the Coronavirus (Covid 19) in the past two weeks?  
If you have been tested, when and what was the result?  
\_\_\_\_\_

\_\_\_ YES \_\_\_ NO Have you been told to isolate due to Covid-19 exposure in the past two weeks?

Do you have any of these symptoms?

\_\_\_ YES \_\_\_ NO Fever

\_\_\_ YES \_\_\_ NO Cough

\_\_\_ YES \_\_\_ NO Shortness of breath

\_\_\_ YES \_\_\_ NO Have you had mammo/us or MRI at another facility since your last visit?  
If so, where? \_\_\_\_\_

**For any new problems, please detail in Section C. If none, please sign and date.**

If your pharmacy has changed, please update:

Pharmacy Name: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Patient Name: \_\_\_\_\_

**Section C:** Please detail **NEW** area(s) of concern.

**For each section, please mark area of concern on the diagram.**

*Please mark all that apply.*

\_\_\_\_ New palpable/thickening area(s) of concern.

\_\_\_\_ Right \_\_\_\_ Left \_\_\_\_ Both

Aprox size: \_\_\_\_ BB \_\_\_\_ Pea \_\_\_\_ Grape \_\_\_\_ Lemon

\_\_\_\_ New nipple discharge.

\_\_\_\_ Right \_\_\_\_ Left \_\_\_\_ Both

Color: \_\_\_\_ Bloody \_\_\_\_ Milky \_\_\_\_ Clear \_\_\_\_ Urine colored

\_\_\_\_ Other (describe): \_\_\_\_\_

\_\_\_\_ Single hole \_\_\_\_ Multiple holes

\_\_\_\_ Does it come out by itself \_\_\_\_ Or with squeezing

\_\_\_\_ New nipple retraction.

\_\_\_\_ Right \_\_\_\_ Left \_\_\_\_ Both

\_\_\_\_ New skin change. Please detail:

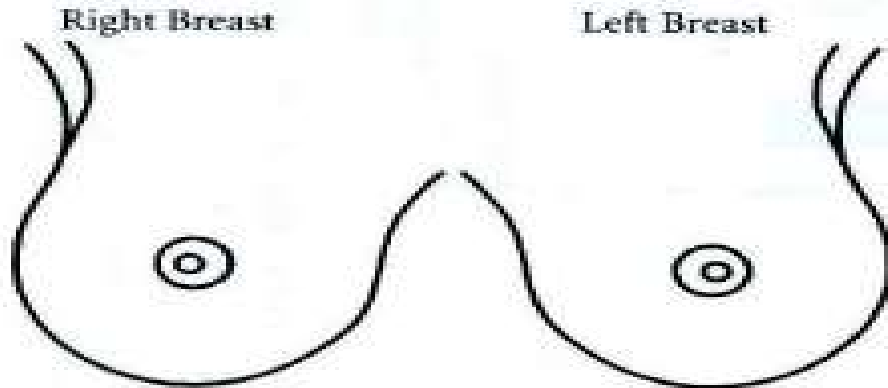
\_\_\_\_\_

\_\_\_\_ New pain/tenderness.

\_\_\_\_ Right \_\_\_\_ Left \_\_\_\_ Both

\_\_\_\_ Focal Area \_\_\_\_ Entire Breast(s)

\_\_\_\_ Other. Please detail: \_\_\_\_\_



Signature: \_\_\_\_\_

Date: \_\_\_\_\_

FOR OFFICE USE ONLY:

MG TECH INITIALS: \_\_\_\_\_

US TECH INITIALS: \_\_\_\_\_