PATIENT INFORMATION SHEET

Complete the sections that apply to you.

Last Name

First Name M.I.

Street Address 1

Street Address 2

City State Zip

Sex (M/F) Marital Status M S W

Referring Physician

Referring Physician's Address

Employer

Person to notify in case of emergency:

Phone

Home Phone #

Work Phone

Mobile Phone #

Date of Birth

Social Security

Occupation:

INSURANCE INFORMATION

PRIMARY INS. CO.

PHONE#: ID#:

ADDRESS:

GROUP NAME/#:

NAME OF POLICYHOLDER:

POLICYHOLDER DOB:

RELATIONSHIP OF PATIENT TO POLICYHOLDER:

SELF SPOUSE CHILD PARENT OTHER

EMPLOYER INS. PLAN? (CHECK ONE) Y N

SECONDARY INS. CO.

PHONE#: ID#:

ADDRESS:

GROUP NAME/#:

NAME OF POLICYHOLDER:

POLICYHOLDER DOB:

RELATIONSHIP OF PATIENT TO POLICYHOLDER:

SELF SPOUSE CHILD PARENT OTHER

EMPLOYER INS. PLAN? (CHECK ONE) Y N

RELATIONSHIP IF OTHER THAN PATIENT

CONCERNING INSURANCE

I **AGREE** **DISAGREE** TO AUTHORIZE WOMEN'S CENTER FOR RADIOLOGY TO FILE INSURANCE ON MY BEHALF FOR COVERED SERVICES RENDERED. I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT. I FURTHER AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING MEDICAL INFORMATION FOR THIS OR ANY RELATED CLAIM, TO MY INSURANCE CARRIER, (OR, IN THE CASE OF MEDICARE PART B BENEFITS TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION). A COPY OF THE AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

THIS AUTHORIZATION MAY BE REVOKED BY EITHER ME OR MY INSURANCE CARRIER AT ANY TIME **IN WRITING.**

ASSIGNMENT OF BENEFITS

I **AGREE** **DISAGREE** TO AUTHORIZE PAYMENT OF ALL MEDICAL INSURANCE BENEFITS WHICH ARE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE POLICY TO BE PAID DIRECTLY TO WOMEN'S CENTER FOR RADIOLOGY FOR SERVICES RENDERED. I FURTHER AUTHORIZE THE RELEASE OF ANY INFORMATION NEEDED FOR PROCESSING MY INSURANCE CLAIMS. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID BY MY INSURANCE COMPANY.

RECORDS RELEASE

I **AGREE** **DISAGREE** TO ALLOW WOMEN'S CENTER FOR RADIOLOGY TO RELEASE MY FILMS, REPORTS, ETC., TO MY REFERRING PHYSICIAN, SPOUSE, OTHER PHYSICIANS, OTHER RADIOLOGY GROUPS, INSURANCE CARRIERS, ATTORNEYS, ETC. THIS AUTHORIZATION TO RELEASE X-RAYS, REPORTS, ETC., WILL REMAIN IN EFFECT UNTIL IT IS REVOKED BY ME **IN WRITING.**

I HAVE RECEIVED THE PATIENT BILL OF RIGHTS AND THE NOTICE OF PRIVACY PRACTICES.

Patient's Signature Date

We would like to thank you for keeping your appointment today and appreciate the opportunity to provide you with professional health care.

Name: ________________________________DOB:______________________ Age:_________ Jacket #__________

Please Complete to Evaluate Your Risk Assessment:

Age menstruation began_____ Your age at first live birth______ Menopause Age_______ Weight_______ Height________

HRT ☐ Yes ☐ No Ashkenazi ☐ Yes ☐ No

Any Symptoms	☐ No			**Notes:**
Lump	☐ Yes	☐ Right	☐ Left	______________________
Nipple Discharge	☐ Yes	☐ Right	☐ Left	______________________
Pain/Soreness	☐ Yes	☐ Right	☐ Left	______________________
Skin Changes	☐ Yes	☐ Right	☐ Left	______________________
Other Concerns	☐ Yes	☐ Right	☐ Left	______________________

Your Personal History:

Breast Cancer	☐ Yes	☐ Right	☐ Left	Age_______
Lumpectomy	☐ Yes	☐ Right	☐ Left	Age_______
Mastectomy	☐ Yes	☐ Right	☐ Left	Age_______
Radiation/Chemo	☐ Yes	☐ Right	☐ Left	Age_______

Tamoxifen or current treatment____

Radiation to your chest between ages 10-30 for Lymphoma/Hodgkin's ☐ Yes

Breast Biopsy:

Cyst Aspiration	☐ Right	☐ Left	#_______	Age_______
Core Biopsy	☐ Right	☐ Left	#_______	Age_______

Breast Surgery:

Excisional Biopsy	☐ Right	☐ Left	#_______	Age_______
Atypical Hyperplasia	☐ Right	☐ Left		Age________
Lobular Hyperplasia	☐ Right	☐ Left		Age________
Reduction/Lift		☐ Yes		Age________
Implants: Saline/Silicone		☐ Yes	☐ No	Age________
Implants Removed		☐ Yes		Age________

Other____

Family History of Breast Cancer:

Mother	☐ Yes	Age______________	Aunt(s)	M/P	☐ Yes	Age(s)_____________
Sister(s)	☐ Yes	Age(s)____________	Cousin(s)	M/P	☐ Yes	Age(s)_____________
Daughter(s)	☐ Yes	Age(s)____________	Male Relative(s)	M/P	☐ Yes	Age(s)_____________
Grandmother(s) M/P	☐ Yes	Age(s)____________	Other Relative(s)	M/P	☐ Yes	Age(s)_____________

Have you had Genetic Testing ☐ Yes Results_______________________________

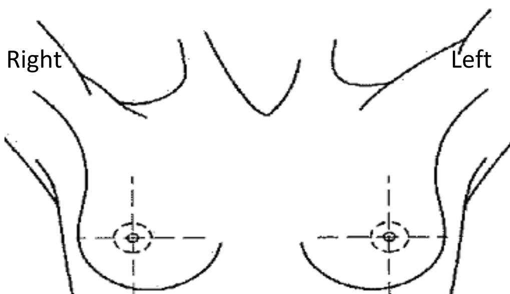
Relatives Genetic Tested__________________________ Results_______________________________

Personal Cancer:			**Relatives with cancer:**
Ovarian	☐ Yes	Age_________	______________________
Uterine	☐ Yes	Age_________	______________________
Thyroid	☐ Yes	Age_________	______________________
GYN	☐ Yes	Age_________	______________________
Other________________		Age_________	______________________

Patient Signature: ______________________________________Today's Date:_______________________

For office use:

*Prior*___________ *Released Signed*____________ *Pregnant*_________ *Breast Feeding*______



Tyrer Cuzick____________________

Notes:____

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Tech:______________________

PATIENT INFORMATION FOR BREAST IMAGING

In requesting an evaluation of my breasts with a mammogram, ultrasound, other breast imaging, or biopsy procedure, I accept the following:

LIMITATIONS OF MAMMOGRAPHY
I understand and accept that no test, including mammography, is 100% effective in finding breast cancer. No assurance is made that cancer is not present when the tests are normal. Dense breast tissue, scars from injury or surgery, infections, inflammation, breast implants, non-cancerous breast masses, and other conditions may limit a mammogram from finding breast cancer.

PREVIOUS MAMMOGRAMS AND REPORTS FROM OTHER PLACES
If my previous mammograms were not performed at Women's Center for Radiology, I accept the responsibility to locate and bring my previous mammogram films and reports to my mammography appointment. If I do not have the previous films today, I agree to bring them as soon as possible so that they can be compared to my current mammogram. I understand that a delay in bring my films for comparison my result in a delay in diagnosis.

BREAST PHYSICAL EXAM
Some cancers can only be found during a physical exam or self-examination. Mammography does not replace a physical exam by my doctor. If I have not had a breast physical exam within the past month, I will ask my doctor to perform one. I should be performing monthly breast self-examinations. A physical examination will not be performed by the radiologist or technologist.

MAMMOGRAPHY HISTORY SHEET
If I have a current problem such as a lump, discharge (leaking fluid), skin dimpling, change in the nipple, or focal breasts pain, or if something else is wrong with my breasts, I will describe what I feel and/or see on my Breast History Sheet. I will sign and date the Breast History Sheet to document my review and acceptance of the contents.

SCREENING MAMMOGRAMS
Screening mammograms are only for patients who are not currently have any breast problems. If I am scheduled for a screening mammogram and I have a problem such as I think I feel a lump, or my doctor felt a lump, I will notify the technologist before she takes my mammogram.

COMMUNICATION OF RESULTS
Women's Center for Radiology will mail the report to your physician whose name is entered into my medical records during registration. I will contact that doctor for an explanation of the results and to arrange any needed additional testing. I will not assume that the results are normal if I do not hear from my doctor.

IF MY MAMMOGRAM REPORT IS NORMAL AND I AM STILL CONCERNED
I accept the responsibility to ask my doctor for a surgical referral if the mammogram is normal and I am still concern. If my doctor told me that my physical exam is abnormal and the mammogram is normal, I will ask my doctor if a biopsy and/or other testing is needed.

I have read and understand the above information. I have been given the opportunity of having this form read to me in a language I understand. I understand that there are limitations to mammography and breast imaging. Questions regarding my responsibilities have been answered to my satisfaction. I have been offered a copy of this form for future reference.

______________________________ __________________
Patient/Parent/Legal Representative's Signature Date

Women's Center For Radiology

1621 N. MILLS AVENUE (17-92)
ORLANDO, FL 32803

1718 S. ORANGE AVENUE
ORLANDO, FL 32806

(407) 841-0822
(800) 367-1870
(407) 841-0411 fax
wcrorlando.com

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION REGARDING MEDICAL RECORDS

The enclosed films are the property of Women's Center for Radiology, P.A. as specified by Florida State Law, 455.667, and must be maintained for a minimum of seven years.

By signing this authorization, I authorize Women's Center for Radiology to use and/or disclose certain protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

This authorization permits Women's Center for Radiology to use or disclose the following individually identifiable health information (specifically describe the information to be released, such as date(s) or service, level of detail to be released, origin of information, etc.)

With my consent, Women's Center for Radiology may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care including laboratory results among others. Women's Center for Radiology may also mail to my home or designated location any items that assist the practice in carrying out TPO such as reminder cards and patient statements.

Women's Center for Radiology reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Women’s Center for Radiology, 1621 N. Mills Ave., Orlando, Florida 32803.

When my information is used or disclosed pursuant to this authorization, it may be subjected 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 Women's Center for Radiology has acted in reliance upon his authorization. My written revocation must be submitted to Women's Center for Radiology at 1621 N. Mills Ave., Orlando, Florida 32803 or your may fax your request to (407) 841-0411.

ORDERING PHYSICIAN/FACILITY____

SIGNATURE ____ DATE _________________

PRINT NAME ____

ACR Accredited Breast Center of Excellence