

**Georgia Breast Care  
PATIENT INFORMATION**

Last Name		First Name		Middle Initial
Your Name as it appears on your insurance card				
Street Address		City	State	Zip
Home Phone		Cell Phone	Work 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		
SS #	Date of Birth	Male or Female	Marital Status	
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 or 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: \_\_\_\_\_

# HIPPA Notice of Privacy Practices

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**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.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

## **1. Uses and Disclosures of Protected Health Information**

### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For Example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

**Other Permitted and Required Uses and Disclosures Will be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.**

You may revoke this authorization, at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### **Your Rights**

**Following is a statement of your rights with respect to your protected health information.**

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You

may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

#### **Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our office manager of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and became effective on **April 14, 2003.**

I hereby acknowledge that I have been provided with the opportunity to obtain a copy of the Georgia Breast Care, P.C. Notice of Private Practices.

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Signature

Date

## **Georgia Breast Care Office Policies and Insurance Guidelines**

**We ask that you call our office 24 hours in advance if you need to cancel your appointment. You will be charged \$25.00 for each un-kept appointment unless we receive the 24 hour notice or we receive a telephone call with an explanation.**

**We do understand that situations arise that are out of your control; however, we must receive a telephone call with as much notice as possible.**

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If you are over the age of 35 and have not had a mammogram, or if you are over the age of 40 and it has been over a year since your last mammogram, please contact our office so that we may help you schedule a mammogram. We have a listing of the screening facilities in the area and will be happy to give you information for each. Many insurance companies offer wellness packages, which pay 100% of your mammogram if it is done at a screening facility. **If you have had mammograms or ultrasound, please make arrangements to bring the films and the radiologist report with you. It is very important that we have those for review.**

If you arrive late or are delayed by referral problems you may miss your appointment time and be required to reschedule.

**If you participate with a managed care plan, please be prepared to pay a co-pay and/or your co-insurance amount at the time of service, which is required in your contract.**

**While we will assist you in any way to assure that your insurance claim is submitted and paid, it is the patient's responsibility to be familiar with the requirements of their individual insurance plan.** Please be sure to check with your insurance carrier prior to arriving for your office visit to see if a referral is required from your primary care physician. Also, please remember to inform us if your insurance does not cover diagnostic testing such as an ultrasound. Please ask your primary care physician to include this diagnostic test in their referral. In addition, please be aware that Medicare and many managed care plans do not allow us to bill for laboratory testing, therefore, you may receive a separate statement from DIANON, Tri County Pathology, Quest, CBL, US Labs or other facilities for laboratory services. If your insurance requires that a specific Lab be used, please advise us before your lab services are obtained.

In the event that your coverage has changed, lapsed, or expired on the date that services are rendered, all charges will be denied and ultimately become your responsibility. ***In order to avoid this, please provide us with your most current insurance card each time you are seen in our office and keep us advised of any insurance or policy changes as they occur.***

If you have any questions regarding the enclosed information, please do not hesitate to contact the office. Our office staff may be able to assist you with questions concerning your insurance requirements.

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**I have read this statement and understand its contents. I agree to abide by the rules set forth in this document.**

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**Patient Signature**

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**Date**

**RELEASE OF PATIENT INFORMATION**

I authorize Georgia Breast Care to release information concerning my care to the following family members or associates:

\_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_ Relationship \_\_\_\_\_

**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 authorizes the Staff Physician (s), or Nurse Practitioner to examine and treat the above patient.
3. Georgia Breast Care 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 Georgia Breast Care 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 custodian.
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 custodian 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. I also understand that all appointments require a 24 hour notice of cancellation. If the appointment is cancelled less than 24 hours, a fee of \$25 will be billed directly to me.

Patient authorizes payment of medical benefits to Georgia Breast Care for services rendered.

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

**PRIVACY PROTECTION NOTICE**

I have received and understand the "Notice of Privacy Protection Practices" from Georgia Breast Care, P.C.

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

(Signature)

**FOR OFFICE USE ONLY**

Received by: \_\_\_\_\_ Data Entered by: \_\_\_\_\_ Scanned by: \_\_\_\_\_

**NEW PATIENT INFORMATION FORM** (please be complete)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Who is the Doctor that sent/referred you to our office? \_\_\_\_\_

Who is your Internist/Family Doctor? \_\_\_\_\_ Ob/Gyn? \_\_\_\_\_

**WHAT IS THE REASON FOR YOUR VISIT TODAY?** (please check all that apply)

New Problem

Follow up for an old problem

Abnormal Mammogram

Abnormal Ultrasound

Abnormal Breast MRI

Breast Pain

Nipple Discharge

Rash/Skin Changes

Breast Mass

Family History of Breast Cancer

Personal History of Breast Cancer

Other (please elaborate) \_\_\_\_\_

When did you first notice current breast concern? \_\_\_\_\_ Location:  Right Breast  Left Breast

Severity or size? \_\_\_\_\_ Recent changes (severity, size, etc.) \_\_\_\_\_

Any associated symptoms for current breast concern? \_\_\_\_\_

Date and Location of most recent Mammogram and/or Ultrasound: \_\_\_\_\_

**Breast Health Information:**

1. Do you have breast implants?

Yes  No If Yes please answer questions below.

When was your surgery? \_\_\_\_\_

What Doctor performed your surgery? \_\_\_\_\_

Are your implants Saline or Silicone? \_\_\_\_\_

2. Have you ever had a breast biopsy?

Yes  No If Yes please answer questions below.

Right Breast  Left Breast

When was your biopsy? \_\_\_\_\_

What type of biopsy was performed? \_\_\_\_\_

Diagnosis/Results of biopsy? \_\_\_\_\_

What Doctor performed your biopsy? \_\_\_\_\_

Please list any additional previous breast problems, breast surgery, or breast cancer treatments: \_\_\_\_\_

**MEDICAL HISTORY**

**MEDICATION YOU TAKE** (include aspirin, over-the-counter, vitamins, and herbal medications): \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**MEDICAL HISTORY CONTINUED**

**PATIENT MEDICAL HISTORY**

Diabetes.....	No	Yes	Kidney Problems.....	No	Yes	HIV or AIDS.....	No	Yes
Excessive Bleeding.....	No	Yes	Hepatitis or Jaundice.....	No	Yes	Asthma.....	No	Yes
Stroke.....	No	Yes	Thyroid Disease.....	No	Yes	TB.....	No	Yes
Anemia.....	No	Yes	Ulcers.....	No	Yes	Emphysema.....	No	Yes
Blood Clots.....	No	Yes	Clots to Lung/Phlebitis.....	No	Yes	Depression/Anxiety.....	No	Yes
Heart Problems.....	No	Yes	Liver Problems.....	No	Yes	High Cholesterol.....	No	Yes
Heart Attack (MI).....	No	Yes	Seizures.....	No	Yes	High Blood Pressure.....	No	Yes
Heart Surgery.....	No	Yes	Arthritis.....	No	Yes		No	Yes

Other Health Conditions: \_\_\_\_\_

Breast Cancer     Ovarian Cancer     Other Cancers: \_\_\_\_\_

MEDICATION ALLERGIES: \_\_\_\_\_

PREVIOUS SURGERIES OR OPERATIONS (please list type and date): \_\_\_\_\_

Removal of Uterus?  Yes     No                      Removal of Ovaries?  No     Yes    If yes...  Left     Right

Reasons for hospital admissions NOT involving surgery: \_\_\_\_\_

**FAMILY HISTORY**

Has anyone in your family had any of the following?

High Blood Pressure.....	Yes	No	Heart Failure.....	Yes	No
Diabetes.....	Yes	No	Heart Attack.....	Yes	No
Stroke.....	Yes	No	Other:	_____	

Family History of Breast Cancer?  Yes     No

(If yes please list approximate age of each relative when they were diagnosed with BREAST cancer below)

First Degree Relatives:	Mother _____	Daughter(s) _____	Sister(s) _____	Father _____
Mother's side:	Grandmother _____	Aunt(s) _____	Cousin(s) _____	Other _____
Father's side:	Grandmother _____	Aunt(s) _____	Cousin(s) _____	Other _____

Family History of Ovarian Cancer?  Yes     No

(If yes please list approximate age of each relative when they were diagnosed with OVARIAN cancer below)

First Degree Relatives:	Mother _____	Daughter(s) _____	Sister(s) _____	
Mother's side:	Grandmother _____	Aunt(s) _____	Cousin(s) _____	Other _____
Father's side:	Grandmother _____	Aunt(s) _____	Cousin(s) _____	Other _____

Family History of Pancreatic Cancer?  Yes     No

(If yes please list approximate age of each relative when they were diagnosed with PANCREATIC cancer below)

First Degree Relatives:	Mother _____	Daughter(s) _____	Sister(s) _____	Father _____
Mother's side:	Grandmother _____	Aunt(s) _____	Cousin(s) _____	Other _____
Father's side:	Grandmother _____	Aunt(s) _____	Cousin(s) _____	Other _____

Are you of Ashkenazi Jewish Descent?  Yes     No

Have you or any family members ever been tested for the *BRCA 1* and *BRCA 2* gene mutation?  Yes     No

If yes, Who? \_\_\_\_\_ Were the results positive?  Yes     No

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

### PERSONAL HISTORY

Alcohol use?  Yes  No

Do you currently or have you previously used illicit or non-prescriptive drugs?  Yes  No

Do you currently smoke?  Yes  No For how long and how much? \_\_\_\_\_

Please list amount of servings per day: Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Cola \_\_\_\_\_ Chocolate \_\_\_\_\_

### REVIEW OF SYMPTOMS

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING COMPLAINTS?  
PLEASE CHECK IF PRESENT

**Genitalurinary:** Frequent urination  Vaginal Bleeding

**Skin Trouble:** Rash  Yeast  Acne  Rosecea  Eczema

**Hematologic/Lymphatic:** Swollen Glands  Arm Swelling  Easy Bleeding

**Respiratory:** Shortness of Breath  Persistent cough

**Eyes:** Cataracts

**Neurological:** Numbness  Memory Loss  Seizures

**Endocrine:** Excessive thirst  Excessive urination

**Constitutional:** Weight Gain  Weight Loss  Hot Flashes

**Cardiovascular:** Chest pain  Leg/Feet swelling

**Gastrointestinal:** Indigestion  Blood in stool

**Psychiatric:** Depression  Sleep disturbances  Fatigue

### OB/GYN HISTORY

Height \_\_\_\_\_ Weight \_\_\_\_\_

Race (please check):  African-American  White  Asian  Hispanic  Native American  Other \_\_\_\_\_

Age menstrual periods began: \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_

Are you pregnant?  Yes  No If yes, how far along are you? \_\_\_\_\_

Are you currently or have you recently stopped breastfeeding?  Yes  No If yes, how long? \_\_\_\_\_

Have you gone through or are you having symptoms of menopause?  Yes  No  Currently  
If yes, at what age? \_\_\_\_\_

Have you ever taken hormones?  Yes  No Approximate dates: \_\_\_\_\_

Do you currently take hormones? (including birth control)  Yes  No What Kind? \_\_\_\_\_

Current hormone dosage: \_\_\_\_\_ How long? \_\_\_\_\_