digital mammography specialists

New Patient Registration Form

Last Name: ______________________ First Name: ______________________ MI: ________

Date of Birth: _____/_____/__________ Social Security#: ______________________

Address: ____

City: __________________ State: ______________ Zip: ______________

Phone Number: Cell: ________________ Home: ________________ Work: __________

Email Address: ____

Does DMS have your permission to leave messages at the numbers listed above? Yes_________ No_________

Physician: (Doctor listed will receive your results) ______________________________

Primary Insurance Information

Subscriber Name: (Last,First,MI) ______________________ Date of Birth: _____/_____/_____

Relationship to patient: ________________ Subscriber Social Security#: ________________

Insurance Company: ________________ Policy ID: ________________ Group#: __________

Secondary Insurance Information

Subscriber Name: (Last,First,MI) ______________________ Date of Birth: _____/_____/_____

Relationship to patient: ________________ Subscriber Social Security#: ________________

Insurance Company: ________________ Policy ID: ________________ Group#: __________

Emergency Contact

Contact Name: ______________________________ Phone: ________________

Relationship to patient: ____

Contact Street Address: ____________________ City: __________ State: ______ Zip: ______

I, the patient/guardian, attest that the information completed above is accurate. I understand that this information will be kept on file and will be used for billing purposes.

Patient/Guardian Signature ______________________________ Date ________________

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MAMMOGRAM INFORMED CONSENT

1. I understand that a mammogram is only 90% accurate in detecting breast cancer, and is only a partial examination for diagnosing breast cancers.
2. I understand based on my clinical symptoms that I may be referred for additional mammogram images for an ultrasound, or to a surgeon.
3. I understand that I am responsible for getting my results if I have not heard from my physician after two weeks.
4. I understand that if I continue to have breast problems after my mammogram (regardless of a negative report on the mammogram) that I need to contact my physician for instructions on a further follow up.

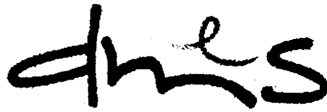
IMPORTANT

By signing this authorization, I understand that the FDA recommends annual screening mammograms after the age of 40. I understand that my insurance may not cover this exam if I have not yet reached the recommended age of 40 or I have not met my plan requirements.

Many insurance carriers allow only one mammogram screening every 12 months. I acknowledge it is my responsibility to understand my insurance benefits pertaining to screening mammograms, diagnostic mammograms, breast ultrasounds, and bone density or DEXA scans. I understand that if it has been less than 1 year and 1 day since my last mammogram, I may be responsible for today's charges.

I hereby authorize the release of my medical and/or other information required for processing my insurance claim from my insurance carrier to DMS. I, the Guarantor hereby acknowledge and accept responsibility for payment in full for all services rendered by Digital Mammography Specialists-Conyers, LLC should my insurance company not cover these services.

Patient/Guardian Signature_____________________________ **Date**__________________



INSURANCE ASSIGNMENT AND FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

INSURED PATIENTS

I, the undersigned, certify that I (or my dependent) have active insurance coverage with ______________________ ______________________________________ and assign directly to Digital Mammography Specialists – Conyers, LLC all insurance benefits, if any, otherwise payable to me for services rendered.

I hereby authorize the facility to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

I further understand:

All co-payments, deductibles and non-covered services must be paid upon receipt of your first statement. If you are unable to pay this amount in full, you must request and complete in full at the time of the service.

A schedule of fees for our services is available at the reception desk.

Digital Mammography Specialists – Conyers, LLC will submit claims to my insurance company as a service to me. It is my responsibility to understand my insurance benefits and coverage. I understand services not covered by my insurance are my responsibility.

If my insurance company requires a referral or preauthorization from my referring physician, it is my responsibility to request and obtain this and submit to my insurer. Digital Mammography Specialists – Conyers, LLC is not responsible to obtain this authorization; and, I understand that failure to obtain necessary authorizations may lead to a denial of benefits and additional financial responsibility on my part.

UNINSURED OR SELF-PAY PATIENTS

I, the undersigned, understand and acknowledge that I am financially responsible for all charges resulting from services rendered at Digital Mammography Specialists – Conyers, LLC. for all dates of service for which I am uninsured.

I understand that payment is due at the time of service and that a schedule of fees for services is available at the reception desk. Digital Mammography Specialists – Conyers, LLC. accepts cash, checks and credit/debit cards.

I further understand that if I am unable to pay for services in full, I may be eligible for a payment plan if I agree to all of the terms and conditions contained in the payment agreement including, but not limited to, authorizing automatic monthly payments.

I understand failure to pay according the terms of my payment arrangement will result in my account being referred to a collection agency and my delinquency reported to the three major credit companies.

I have read the above Acknowledgements and Agreements and fully understand the same.

______________________________________   ________/________/________

Signature of Patient or Guardian   **Date**

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3D Digital Mammography (Tomosynthesis)

Digital Mammography Specialists (DMS) now offers 3D tomosynthesis mammography. **3D mammography is performed at the same time as your 2D exam and uses the same imaging procedure. There is no additional compression and takes just seconds longer.**

2D breast mammography images your breast tissue in on flat image. **3D mammography is the latest FDA approved technological advancement producing images of your breast tissue in several slices, allowing the radiologist to see breast detail in a more advanced way than before.** The radiologist can scroll through pictures of your entire breast like the pages of a book (3D), rather than only one image (2D).

Why have a 3D mammogram?

- **3D mammography finds 40% more invasive cancer missed with conventional 2d mammography and your chances of being called back are 20-40% less.**
- **Our breast imaging radiologists recommend 3D mammography for all patients.**

What is your cost?

Currently, most commercial insurances (including, but not limited to: BCBS, United Healthcare, Cigna, Aetna, Medicare, Humana, and Coventry) considers 3D mammography an eligible benefit towards the preventive care. For patients whose insurances does not reimburse for this service, DMS is happy to provide this service for a fee of $75.00, payable in advance at the time of service. Self-pay patients are offered this technology for only $250.00. Patients who are interested in a payment plan, we require half of this payment at the time of service.

_________ Yes, I would like to add 3D tomosynthesis to my mammogram today.

_________ No, I do not wish to have 3D tomosynthesis to my mammogram today.

____ ________/________/__________

Patient Signature Date

PATIENT COPY – PLEASE RETAIN FOR YOU RECORDS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The Health Insurance Portability & Accountability Act of 1996 (**"HIPAA"**) is a federal program that requires that all medical records or other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we disclose your health information.
DMS Inc., will not condition treatment or payment on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Covered Entity may use or disclose your medical records for the purpose(s) of treatment, payment and healthcare operations.

By signing this authorization you agree that Covered Entity or its Business Associates may disclose your personal health care information to your physician and insurance carrier.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Covered Entity at any of its offices or by sending a written request with return address to 3242 Avalon Blvd., Conyers, GA 30013.

In accordance with your rights under, and subject to certain restrictions imposed by HIPAA, you may inspect or copy your PHI (*Protected Health Information*) in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing at any time, except to the extent that the Covered Entity has taken action in reliance on it. If you choose to revoke this authorization, it is effective upon receipt of a written request to revoke and a copy of the executed form sent to the address listed above.

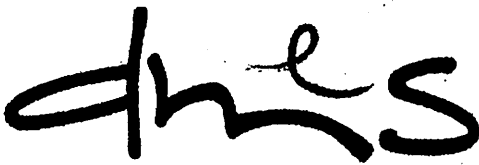
This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity, or (d) six years from the date this authorization was executed.

By signing the authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Covered Entity has provided me with a copy of this notice.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Phone (202) 619-0257
Toll Free: 1-877-696-6775



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ACKNOWLEDGEMENT - NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions.

Patient Name: ________________________________ **Date of Birth:** ____/______/________

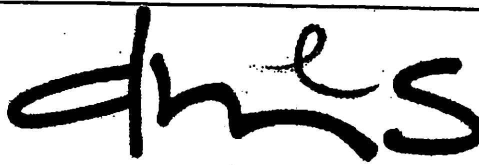
Signature: ________________________________ **Date:** ________/________/__________

OFFICE USE ONLY – PATIENT REFUSAL

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so as documented below.

Reason:____

Employee Name:______________________ Date____/____/____



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AUTHORIZATION FOR RELEASE
MAMMOGRAM IMAGES & BREAST HEALTH INFORMATION

Patient Name:________________________________ **Date of Birth:** ____/_____/_____

Patient Social Security Number:_______-______-________

Date of PRIOR EXAM: _____/_____/_____ **or No Previous Exams – Patient Initials**________

Please check or list the location below of where your prior mammogram was performed:

Rockdale Medical Center	Newton Medical Center
Emory	Eagles Landing Family Practice
Grady	Henry Medical
McDonough Diagnostic	Radiology Associates of Clayton
South Atlanta Radiology	Southern Regional
Spalding Regional	Piedmont Hospital
DeKalb Medical Center	Piedmont Fayette Hospital
Name of Facility with City & State	

I hereby authorize the practitioner and/or the facility listed above to release my mammogram films/discs, mammogram and/or pathology reports, and any other information pertaining to my breast history to Digital Mammography Specialists – Conyers, LLC.

Please forward all **FILMS** and **DISCS** to:
DMS
3242 Avalon Blvd.
Conyers, GA 30013

Phone: 678-904-6823, Option 3
Fax: 770-679-1425

Signature of Patient: ______________________________ **Date:** _______/_______/_______

For Office Use Only

Request By: ______________________________________ **Date:** ______/______/_______

Fax Number: ______________________________

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Mammography History Sheet

Today's Date: ______/______/________

Patient Name: ____

Patient's Date of Birth: ______/_______/_________ **Last Menstrual Cycle**______/______/______

Are you currently pregnant or breast feeding? YES NO

Have you ever had a mammogram? YES NO

If YES - Place of last Mammogram: ______________________________ Date of Last Mammogram: ____/___/_____

Do you currently have any new breast problems that have occurred since your prior mammogram? YES NO

If YES – Please provide details:____

YES	NO		Right	Left
_____	_____	Do you have any **NEW** lump(s) in either breast?	_____	_____
_____	_____	Pain or discomfort?	_____	_____
_____	_____	Discharge from nipple: Color __________	_____	_____

Please check if you have had any of the following:

YES	NO		Right	Left
_____	_____	Mastectomy	_____	_____
_____	_____	Lumpectomy (removal of Breast Cancer)	_____	_____
_____	_____	Radiation	_____	_____
_____	_____	Chemotherapy	_____	_____
_____	_____	Benign (**Not Cancerous**) biopsy	_____	_____
_____	_____	Augmentation (**Implants**)	_____	_____
_____	_____	Reduction	_____	_____

Personal history of cancer? YES NO

Area of body affected? ______________________

Age of first menstrual period _________

Was your first pregnancy before age 35? YES NO

Number of full pregnancies _________

Did you breast feed? YES NO

Have you had a hysterectomy? YES NO

When was your hysterectomy? __________________

Are you taking hormones? YES NO

How long have you been taking hormones? ___________

Family history of BREAST CANCER? YES NO

Age relative was diagnosed? ____________________

Check all that apply ____Mother____Sister____Daughter_____Aunt_____Grandmother or Other ___________

TECHNOLOGIST SECTION

Please identify location of any: Lumps (X) Previous Surgery (X) Moles (O)