
digital mammography specialists

## Returning 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: (Last,First,MI)_____ 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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# 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 one 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: Cigna, BCBS, United Healthcare, Aetna, Medicare and Coventry) considers 3D mammography an eligible benefit towards the preventive. For patients whose insurances does not yet 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**

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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? _____

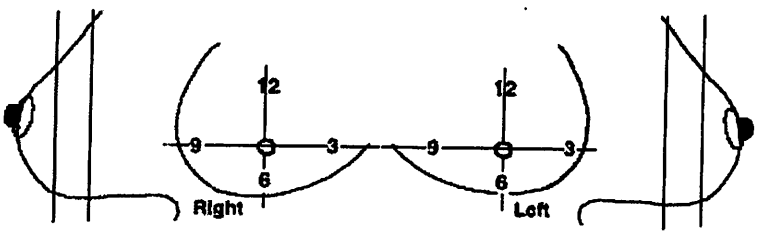
Family history of BREAST CANCER? YES NO

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)**



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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**_____