# New Patient Information

**PLEASE PRINT**

Referring Physician: _____ Phone: _____

SS#: _____/_____/_____ D.O.B _____/_____/_____ Age: _____

Name: *(Last, First, MI)* _____

Address: *(Street, City, ST, Zip)* _____

Address: *(if different from mailing)* _____

Home phone: _____ Work phone: _____ Cell: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Minor/Child

Email: _____

**Employer:** _____

**Employer Address:** *(Street, City, ST, Zip)* _____

**Emergency Contact**: _____ **Relation:** _____

**Address:** _____ **Phone:** _____

**INSURANCE INFO *(PLEASE FILL OUT COMPLETELY)***

**Policy 1**

Insurance Name: _____

Name of Insured: _____

Relation to Insured: _____

Gender: ☐ Male ☐ Female

**Insured DOB:** _____

**Insured SS#:** _____

**Insured Employer:** _____

**Insured Employer Phone:** _____

**Employer Address:** _____

Subscriber/Policy#: _____

Group#: _____ Co pay: _____

**Policy 2**

Insurance Name: _____

Name of Insured: _____

Relation to Insured: _____

Gender: ☐ Male ☐ Female

**Insured DOB:** _____

**Insured SS#:** _____

**Insured Employer:** _____

**Insured Employer Phone**: _____

**Employer Address:** _____

Subscriber/Policy#: _____

Group#: _____ Co pay: _____

**AUTHORIZATION (*SIGN BELOW*)**

*I hereby agree that the above information is correct and acknowledge that it is my responsibility to inform us of any changes in this information as soon as you are aware of the changes.*

Patient Name: _____ DOB: _____

**Signature:** _____ **Date:** _____

TUCSON
*Breast Health Specialists*

Revised 2024

# Patient History

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Occupation: _____

**For what problem did you come to the doctor today?** _____

**First noticed when?** _____ **Location:** _____ **Severity or size:** _____

**Recent changes?** _____ **Any associated symptoms?** _____

Any associated possible causes?*(stress, medicines, menstrual cycle)*: _____

Had a similar problem before? *(note when and how resolved)*: _____

**Doctor who sent you here?** _____

**Who is your PCP/Family Doctor?** _____ **OB/Gyn?** _____

**List medicines you cannot take because of ALLERGY or side effects** *(please note type of reaction)*:

_____

_____ ☐ No Allergies

**List medicines you do take** *(include aspirin, over-the-counter, supplements)* ☐ No Medications Taken

_____

_____

_____

**Medical Problems You Have?** (*Please check ALL that apply)*

| | | | |
|---|---|---|---|
| ☐ Diabetes | ☐ Kidney Problems | ☐ HIV or AIDS | ☐ Heart Problems |
| ☐ Excessive Bleeding | ☐ Hepatitis or Jaundice | ☐ Asthma | ☐ Heart Attack (MI) |
| ☐ Stroke | ☐ Thyroid Disease | ☐ TB | ☐ Heart Surgery |
| ☐ Anemia | ☐ Ulcers | ☐ Emphysema | ☐ High Blood Pressure |
| ☐ Clotting or bleeding disorder | ☐ Autoimmune Disorder | ☐ Depression/Anxiety | ☐ High Cholesterol |
| ☐ Cancer-What kind: _____ | | | ☐ Arthritis |
| ☐ Other: _____ | | | |

**Age menstrual periods began:** _____ Date of last menstrual period: _____ Number of children: _____

How many times have you been pregnant? _____ Age at delivery of first live child: _____

Have you ever taken birth control pills? _____ Approximate dates: _____

Have you ever taken hormones?_____ What kind?_____ Dose?_____ How long?_____

**Have you ever had a Breast Biopsy?** ☐ Yes ☐ No If yes, when? _____ Outcome? _____

**Have you had your Uterus removed?** ☐ Yes ☐ No If yes, when? _____ Outcome? _____

**Have you had your Ovaries removed?** ☐ Yes ☐ No If yes, when? _____ Outcome? _____

Race: ☐ African-American ☐ White ☐ Asian ☐ Hispanic ☐ Native American ☐ Other _____

Preferred Language: _____

# Patient History

Name: _____ Today's Date: _____

**Previous operations and approximate dates:** _____

_____

_____

_____

**Approximate dates and reasons for hospital admissions NOT involving surgery (including childbirth):**

_____

_____

_____

**FAMILY HISTORY: Has anyone in your family had any of the following?**
***If YES, indicate that person's relation to you, otherwise, check NO.***

High Blood Pressure: ☐ NO ☐ YES: _____ Heart Attack: ☐ NO ☐ YES: _____

Heart Failure: ☐ NO ☐ YES: _____ Stroke: ☐ NO ☐ YES: _____

Diabetes ☐ NO ☐ YES: _____ Anything that runs in the family: ☐ NO ☐ YES: _____

Cancer: ☐ NO ☐ YES: _____ What type? _____

Do you smoke? ☐ NO ☐ YES: If yes: Packs per day? _____ How long? _____ If quit: How long ago? _____

Servings per day: Coffee _____ Tea _____ Cola _____ Chocolate _____

Present alcohol use: _____ Past alcohol use: _____

**Have you recently had any of the following?** *(Please state **YES** if present and **check** if given choices.)*

**Constitutional:** ☐ Weight loss or gain (if so, how much) _____ ☐ Cold or flu ☐ Fatigue/Lethargy

**Neurological:** ☐ Blindness ☐ Fainting ☐ Weakness on one side ☐ Seizures

**Respiratory:** ☐ Smothering ☐ Wake up short of breath ☐ Persistent cough ☐ Difficulty Breathing Deeply

**Cardiovascular:** ☐ Short of breath lying flat ☐ Chest pain like a heart attack ☐ Swelling (where?): _____

**Gastrointestinal:** ☐ Indigestion ☐ Vomiting ☐ Diarrhea ☐ Blood in stool ☐ Constipation

**Urinary:** ☐ Trouble passing urine ☐ Frequency ☐ Urgency ☐ Pain

**Musculoskeletal:** ☐ Shoulder, Back, Neck or Chest Pain ☐ Arthritis ☐ Muscular or Joint Pain/Tightness
☐ Stiffness ☐ Limited Range of Motion ☐ Weakness ☐ Difficulty in Daily Tasks (Dressing, etc.)

**Skin Disorders:** ☐ Explain: _____ **Lymphatic:** ☐ Swelling in glands

**Psychiatric:** ☐ Depression ☐ Anxiety ☐ Suicidal thoughts: _____

**Endocrine:** ☐ Excessive thirst or urination ☐ Feeling too hot or cold

**Name, address and phone number of your pharmacy:** _____

_____

**Breast Health Information:** Please list any previous breast problems or breast surgery: _____

_____

# Family History

YOUR PERSONAL & FAMILY HISTORY ARE VERY IMPORTANT IN YOUR CARE
PLEASE COMPLETE THE FOLLOWING FOR THE BEST ASSESSMENT OF YOUR CANCER RISKS

Name: _____ Today's Date: _____

**Please enter the age of diagnosis for any cancer listed below that applies to you or your close blood relatives.**
**If specific age is not known, please estimate if over or under age 50.**
**Please add any details by writing over blank spaces.**

| | BREAST | OVARY | PANCREAS | UTERUS | COLON-RECTUM | STOMACH/ SMALL BOWEL | KIDNEY | OTHER Please list type |
|---|---|---|---|---|---|---|---|---|
| **You** | | | | | | | | |
| **Your Sibling(s)** | | | | | | | | |
| **Your** daughter(s) or son(s) | | | | | | | | |
| **Your Mother** | | | | | | | | |
| **Mother's** mother or father | | | | | | | | |
| **Mother's** sister(s) or brother(s) | | | | | | | | |
| **Mother's side** cousin(s) aunt(s) uncle(s) | | | | | | | | |
| **Your Father** | | | | | | | | |
| **Father's** mother or father | | | | | | | | |
| **Father's** sister(s) or brother(s) | | | | | | | | |
| **Father's side** cousin(s) aunt(s) uncle(s) | | | | | | | | |

**Have you or any member of your family ever had genetic testing? ☐ Yes ☐ No. If yes, please list which test & the results:** _____

**Are you of Ashkenazi Jewish ancestry? ☐ Yes ☐ No**

TUCSON
*Breast Health Specialists*

Tucson Breast Health Specialists ■ 5240 E. Knight Dr ■ Suite 114 ■ Tucson, AZ 85712 ■ Phone: 520-605-2778 ■ Fax: 520-535-2232

# Patient Financial Policy

*This is an agreement between Tucson Breast Health Specialists, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.*

*In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to Tucson Breast Health Specialists. By executing this agreement, you are agreeing to pay for all services that are rendered.*

*Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.*

**HEALTH INSURANCE - It is YOUR responsibility to:**

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

**It is OUR responsibility to:**

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.
- Provide MVA patients a courtesy health insurance claim form for their records upon request.

**PAYMENT OPTIONS:** Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you. Our office collects all copays plus estimated coinsurance and deductibles at the time of service

**We accept the following: Cash Check Credit Card *(Visa, MasterCard, Discove)***

***A twenty-five dollar ($25.00) returned check fee will be assessed to the patient account per incident.***

***Patients who no-show may be subject to a no-show fee.***

**PENDING APPROVALS FOR SERVICES:** In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

_____ Initials

Patient and/or Debtor Signature: _____ Date _____/_____/_____

*Additional financial explanations are continued on the back side of this page*

**WORKERS' COMPENSATION INJURIES:** Written approval/authorization by your employer and/or workers' compensation carrier prior to your initial visit is needed. We will contact your case manager and/or supervisor to confirm your workers' compensation injury. If this claim is denied, for any reason by your employer or your employer's workers' compensation carrier, you will be responsible for payment in full. If denial is made by workers' compensation, health insurance can be filed for these denied services and you will be held responsible for the account.

**MOTOR VEHICLE ACCIDENTS (MVA's)** – Yes, I was involved in a MVA on _____/ _____/ _____. Unless prior agreement has been reached or I am a Medicare recipient, my **health insurance** will be filed for services related to this accident. In the event I do not provide insurance information upon initial visit, I understand insurance denials may occur depending on type of service(s) received or carrier specific filing requirements. I agree, as the patient or patient's guardian, I am ultimately responsible for all balance(s) due to this facility and/or its physician(s) for services rendered regardless of insurance denial(s) or unfavorable case outcomes. If I have chosen an attorney to oversee my case, this financial agreement will serve as a Letter of Protection to my attorney. I further understand my account may be handled by an outside entity that specializes in attorney lien accounts at the facilities discretion.

_____ Yes, I have chosen to retain an attorney. Signed: _____ Date: _____/_____/_____

Attorney Name: _____ Phone: _____

## BILLING INFORMATION

**STATEMENTS:**
A statement of account will be provided to you if insurance has paid leaving a patient portion, denied or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been paid in full, you are required to notify our billing office of this change by calling 520-722-3777. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes, otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less than <$5.00> will not be refunded without specific request from the patient/debtor.

**DELINQUENT ACCOUNTS:**
We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60 days past due, further steps to collect this debt may be taken. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Pima County, Arizona. In addition, we reserve the right to deny future non emergency treatment for any and all debtor-related unpaid account balances.

**WAIVER OF CONFIDENTIALITY:**
You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

**MEDICAL RECORDS:**
You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician. There may be a charge for the service.

# General Consent For Treatment

***As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).***

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _____ **(initial)**

**I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.**

Name of Patient: _____

Signature of Patient: _____ Date: _____

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☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**

☐ Consent Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: _____

Relationship: _____ Telephone: _____

Address: _____

Signature of the above: _____ Date: _____ Time: _____

Signature of Witness: _____ Date: _____

# Notice of Privacy Practices

**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.**

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- **Treatment:** We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.

- **Payment:** We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.

- **Health operations:** We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.

- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.

- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.

- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.

- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fund raising communications.

If you have any questions about our privacy practices, please contact our office.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

**Office for Civil Rights**

http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on 10/01/09.

# Release Of Medical Information

NAME *(Please print)*: _____

By Signing Below, I Authorize Tucson Breast Health Specialists To Release My Medical And Billing Information To:

| **RELATIONSHIP** | | | **NAME OF DESIGNATED PERSON** |
|---|---|---|---|
| SPOUSE | ☐ YES | ☐ NO | _____ |
| CHILDREN | ☐ YES | ☐ NO | _____ |
| IN-LAWS | ☐ YES | ☐ NO | _____ |
| CAREGIVERS | ☐ YES | ☐ NO | _____ |
| PARENTS | ☐ YES | ☐ NO | _____ |

OTHERS _____

PATIENT SIGNATURE _____ DATE _____

PARENT SIGNATURE _____ DATE _____

**We ask that if you have any change in this request, that you please inform the receptionist.**

---

Tucson Breast Health Specialists may leave appointment information on my voicemail:

| | | |
|---|---|---|
| HOME | ☐ YES | ☐ NO |
| WORK | ☐ YES | ☐ NO |
| RELATIVE | ☐ YES | ☐ NO |

PATIENT SIGNATURE _____ DATE _____

---

I authorize the following to pick up prescriptions, X-rays, etc.

| **RELATIONSHIP** | | | |
|---|---|---|---|
| SPOUSE | ☐ YES | ☐ NO | _____ |
| RELATIVE | ☐ YES | ☐ NO | _____ |
| CAREGIVER | ☐ YES | ☐ NO | _____ |

PATIENT SIGNATURE _____ DATE _____

I understand that Tucson Breast Health Specialists will ask for identification of the person picking up patient medical information or products.