TUCSON Breast Health Specialists

New Patient Registration Forms

Today's date: ____/____/_____

Patient Information

First Name	M.I.	Last Name	Date of Birth / /
Address	City	State	Zip Code
Address (If different than mailing)	City	State	Zip Code
Email	Preferred Phone Number ☐ Cell ☐ Work ☐ Home ☐ Other: _____		
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor/child			
Race	Ethnicity	Preferred Language	
Employer	Occupation	Employer Phone Number	
Employer Address	City	State	Zip Code

Emergency Contact

Emergency Contact Name	Relation	Phone Number
Address	City	State	Zip Code

Physician & Pharmacy Information

Referring Physician	Specialty (Family med, oncology, etc.)	Phone Number
Primary Care Physician (PCP)	Phone Number	OB/GYN	Phone Number
Cardiologist	Phone Number	Other provider	Phone Number
Preferred Pharmacy	Phone Number		
Address	City	State	Zip Code

I hereby agree that the above information is correct and acknowledge that it is my responsibility to inform of any changes as soon as I am aware of them.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Patient Medical History

Patient Name: _____ Today's date: ___/___/_____

Do you currently have, or recently had, any of the following symptoms? (Please check ALL that apply)

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 ☐ Change in 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 (where?:_____)

Psychiatric: ☐ Depression ☐ Anxiety ☐ Suicidal thoughts (Explain:_____)

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

Do you have, or have had, any of the following medical conditions? (Please check ALL that apply)

☐ Diabetes
☐ Excessive bleeding
☐ Stroke
☐ Anemia
☐ Clotting or bleeding disorder
☐ Cancer (What kind?: _____)
☐ Other: _____
☐ Heart problems (What kind?: _____)
☐ Kidney problems
☐ Hepatitis or Jaundice
☐ Thyroid disease
☐ Ulcers
☐ Autoimmune disease
☐ HIV or AIDS
☐ Asthma
☐ TB
☐ Emphysema
☐ Depression/Anxiety
☐ Heart Attack (MI)
☐ High blood pressure
☐ High cholesterol
☐ Arthritis

Age menstrual period 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? Y / N Approximate dates taken: _____

Have you ever taken hormones? Y / N What kind? _____ Dose: _____ For how long?: _____

Recent hospital visits NOT involving surgery (including childbirth):

Previous operations and approximate dates:

Patient Medical History

Patient Name: _____ Today's date: ___/___/_____

List ALLERGIES to medications and types of reactions:

☐ No allergies

List CURRENT medications (include aspirin, over-the-counter, supplements):

☐ No medications taken

Upcoming imaging scheduled (include type of imaging and location of service):

Breast Health Information

Please list any previous breast problems:

Please list any previous breast surgery (include surgeon name and location of service):

Family Medical History

Patient Name: _____ Today's date: ___/___/_____

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

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 specify)
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? Y / N

If yes, please specify what test & results: _____

_____

Are you of Ashkenazi Jewish ancestry? Y / N

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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: _____

☐ 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: _____

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Missed Appointment Policy

Purpose
To ensure the efficient use of our time and resources, and to provide the highest quality of care to all patients, we have established a policy regarding missed appointments.

Policy Statement
Patients are expected to attend scheduled appointments. In the event that a patient cannot attend, we request that they notify our office as soon as possible.

Definition
No-Show: A patient who fails to attend a scheduled appointment without providing prior notice.

Late Cancellation
A cancellation that is made less than 24 hours before the scheduled appointment.

Notification Requirements
Patients are required to provide at least 24 hours' notice for cancellations or rescheduling. Notifications can be made via phone or email us at Info@tucsonbreasthealth.com

Consequences of No-Shows
Patients who do not attend their appointment and fail to notify us will be considered a "no-show." After the third no-show, patients will receive a notification regarding our policy.

Dismissal Policy:
Three no-show appointments in a six-month period may result in the patient being dismissed from our practice. A dismissal letter will be sent to the patient informing them of the decision and offering a referral to another surgeon.

Conclusion
We appreciate your understanding and cooperation in this matter. Our goal is to provide exceptional care to all our patients, and adherence to this policy will help us achieve that.

Patient Name: _____

Patient Signature: _____ Date: _____

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Patient Financial Policy

Due to the ongoing changes in healthcare, Tucson Breast Health Specialists may make periodic updates or modifications in our financial policy, which is why we will require each patient to have an updated, signed copy in their chart.

1. We ask that you present your insurance card and photo identification at each visit.

2. All Co-Payments are due at the time of service. Co-payments, co-insurance, and deductibles are a contract responsibility between you and your insurance plan, and we are unable to negotiate or reduce these amounts. We accept cash, check, debit, and credit cards (Visa, MasterCard, and Discover). If you cannot pay full at the time of service, payment arrangements must be made before seeing the doctor. There will be a $35 fee for any check returned to us.

3. HMO patients are responsible for obtaining the required referral/note prior to their office visit. Failure to provide a referral/note when necessary, may result in your appointment being canceled or rescheduled, or you being responsible for payment in full prior to seeing the physician.

4. Our office will submit claims to your insurance company if you provide the necessary documentation. We will only accept assignment of benefits for insurance plans which we participate with. Check with your carrier for coverage limitations; it is important that you understand your policy. Please be aware that you claim's balance is your responsibility whether your insurance company pays it or not.

5. You will receive an Explanation of Benefits (EOB) from your insurance carrier and a statement from our office outlining your financial responsibility. If your balance remains unpaid 30 days after the due date listed on your statement, you will receive final notice before your account is considered delinquent. We reserve the right to refer delinquent accounts to a collection agency, which may report to credit bureaus. Accounts referred to collections will incur a fee of 25% of the outstanding balance.

6. Due to our practice's specialized nature, we may provide services not covered by insurance carriers. The staff will review these additional fees and all patients must sign a waiver before receiving these additional services. These services must be paid for in full at the time of service.

7. Additional testing is a common part of the diagnosis process. Occasionally further testing is needed to ensure our diagnosis is correct. Additional testing will only be ordered when deemed medically necessary. These tests are usually covered by insurance, but you may have a cost share. If your insurance company assesses a copay, coinsurance, or deductible, questions regarding your policy should be addressed directly to your insurance company. Unfortunately, our office has limited access to individual policy requirements and benefits as this is specific to your plan.

8. Filling out FMLA documents: Our office charges a one-time fee of $10.00 to complete the FMLA paperwork.

Our practice is committed to providing the best treatment for our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I acknowledge that I have received, read, and understand the financial policy and agree to abide by its guidelines.

Patient Name: _____ Today's Date: _____

Patient signature: _____

Waiver of Financial Responsibility for Non-Covered Services

At Tucson Breast Health Specialists, we are committed to providing the highest quality care to our patients. Due to the specialized nature of some services we offer, certain procedures, treatments or tests may not be covered by your insurance plan. This waiver outlines your financial responsibility for such services.

By signing this document, you acknowledge and agree to the following terms:

1. Non-covered Services

Some of the services provided by our practice may not be covered by your insurance carrier. These services may include, but are not limited to, specialized screenings, additional diagnostic tests, or elective procedures that are outside of your plan's benefits.

2. Financial Responsibility

You understand and agree that, for any services that are not covered by your insurance, you will be financially responsible for the full cost of the service. Payment for these services is due in full at the time of service.

3. Pre-Service Review

The staff at Tucson Breast Health Specialists will inform you of any services that may not be covered by your insurance, as well as the associated costs. If you choose to proceed with these services, you will be required to sign this waiver to acknowledge your responsibility for payment.

4. Insurance Non-Coverage

You understand that Tucson Breast Health Specialists will not submit a claim to your insurance company for services that are not covered by your insurance. These services are your responsibility, and your insurance will not reimburse you for them.

By signing below, I acknowledge that I have read and understand the terms outlined in this waiver and have been informed of the potential for non-covered services provided by Tucson Breast Health Specialists. I agree to pay the full amount for these services at the time they are provided.

Patient Name: _____ Today's Date: _____

Patient signature: _____

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PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Today's Date: _____

Patient Name:_____

Date of Birth: _____ Phone Number: _____

I hereby authorize Tucson Breast Health Specialists to receive and release my medical records to my care team as needed.

Please select one option below:

☐ I allow the release/receipt to/from all of my care team

☐ I allow the release/receipt to/from ONLY the following provider(s)/individual(s):
_____

- I, the patient, or patient's representative, have the legal right to inspect, copy and request delivery as specified in this Protected Health Information within the next 30 days in accordance with Public Law 104-191 (HIPPA- 1996).

- I accept the responsibility of any fees that may be associated with this request.

- I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation.

By signing below, I hereby authorize the release of medical information / Protected Health Information.

Patient/Representative Signature: _____

Printed Name: _____ Date: _____

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HIPAA PRIVACY PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

With my consent Tucson Breast Health Specialists, its staff, providers, and associates may send me a text message, email or call my cell/home phone or other designated (by me) contact number to leave me a message in reference to any items that may assist the practice in carrying out my medical care, such as appointment reminders, insurance items or clinical care.

Things I understand:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that I can review this Notice at any time.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed: _____

_____ _____

Print Name Date

_____

Signature

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.