



# PATIENT INFORMATIONAL PACKET

Revised 03/25/10

## DEMOGRAPHICS

**MUST BE COMPLETED IN FULL**

DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SECONDARY ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

PRIMARY CARE DR: \_\_\_\_\_ REFERRING DR: \_\_\_\_\_

OTHER TYPE OF REFERRAL: \_\_\_\_\_

(CIRCLE ONE) SEX: MALE FEMALE MARITAL STATUS: SINGLE MARRIED DIVORCED SEPARATED WIDOW

S.S. #: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE #: \_\_\_\_\_

REASON FOR VISIT:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PRIMARY INSURANCE CO:** \_\_\_\_\_ PHONE#: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP #: \_\_\_\_\_

NAME OF POLICY HOLDER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

POLICY HOLDER S.S. #: \_\_\_\_\_ RELATIONSHIP TO INSURED: \_\_\_\_\_

**SECONDARY INSURANCE CO:** \_\_\_\_\_ PHONE #: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP #: \_\_\_\_\_

### **RELEASE INFORMATION:**

I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE CARRIER IS CORRECT. I AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING MEDICAL INFORMATION TO MY INSURANCE CARRIER, ATTORNEY, PHYSICIAN, HOSPITAL, MEDICARE OR OTHER MEDICAL FACILITY

### **ASSIGNMENT OF BENEFITS:**

I REQUEST THE PAYMENT OF BENEFITS (MEDICARE, MEDICAID, OR OTHER INSURANCE CARRIER) BE MADE DIRECTLY TO TEPAS HEALTHCARE, FOR SERVICES FURNISHED TO ME BY TEPAS HEALTHCARE. I AUTHORIZE TEPAS HEALTHCARE TO APPLY FOR BENEFITS ON MY BEHALF.

I have reviewed & understand this page, and have no unanswered questions.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
Date

Patient Name Footer

**FINANCIAL AGREEMENT**

We have composed this agreement to inform you of the financial policy/agreement for **TEPAS Breast Center**.

You are responsible to give us your correct insurance information. If you have any change in insurance it is your responsibility to make sure you bring in a copy of your new insurance card, as soon as possible. This will help us in scheduling procedures or any further testing. **If you do not inform us of any changes and we are not able to get your insurance company to pay, due to delay in receiving this information, you will be responsible for any charges incurred for office visits and/or procedures.**

**HMO & PPO'S:** If we participate with your insurance company, we are responsible to file your claim. You are responsible for any co-payment or deductible amount, or for any non-covered charges. If your insurance requires you to have a REFERRAL OR AUTHORIZATION you are also responsible to make sure it is in our office prior to your scheduled visit. It is your responsibility to make sure your primary care physician follows through with this. We would suggest that you have them mail you the referral or authorization. It is your responsibility to contact them at least 2 weeks prior to your visit, so that they have enough time to get the referral for you. Most physician offices will send a copy of the REFERRAL OR AUTHORIZATION directly to us. Please check with our office prior to your visit to see if we have received your REFERRAL OR AUTHORIZATION. If for some reason you come to your office visit and you do not have the REFERRAL OR AUTHORIZATION you will be responsible to pay for the visit, prior to leaving our office or to reschedule your appointment. **All co-pay's are due at time of service. If you are not able to pay your co-pay at time of service you will be asked to reschedule your appointment.**

Medicare: We accept assignment on all covered charges by Medicare. We will file your charges to Medicare and you're secondary. If you do not have a secondary you will be responsible for 20% of the Medicare allowable charges at the time of service, including office visits and procedures. We will be happy to provide you with an approximate cost prior to being seen by the physician.

Private Policy's: We will file your claim and wait for the insurance response. If we do not participate with your private carrier, you will be responsible for any difference in our charges and what they pay, "Reasonable and Customary" is between you and your insurance company. We use a national fee schedule for our charges, so anything over their "Reasonable and Customary" is your responsibility.

Self Pay: Self Pay patients are responsible for all charges at the time of service. New patients must make payment by Cash or Credit Card only. No checks will be accepted for a new patient visit.

**All payments are due at the time of service.**

I have reviewed & understand this page, and have no unanswered questions.

\_\_\_\_\_

**Patient Signature**                      **Date**

Patient Name Footer

Referring Physician: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

**YES NO**

Have you ever had a mammogram? \_\_\_\_ Don't Know  
If Yes, Where was it performed? \_\_\_\_\_

Are you on hormone replacement therapy? \_\_\_\_ Don't Know

Have you had a breast reduction? \_\_\_\_ Don't Know

Do you have breast implants? \_\_\_\_ Saline \_\_\_\_ Silicone

Have you ever had a breast biopsy? \_\_\_\_ Right \_\_\_\_ Left

Have you ever been diagnosed with breast cancer? \_\_\_\_ Right \_\_\_\_ Left

Have you ever had a mastectomy? \_\_\_\_ Right \_\_\_\_ Left

Is there any possibility you are pregnant?

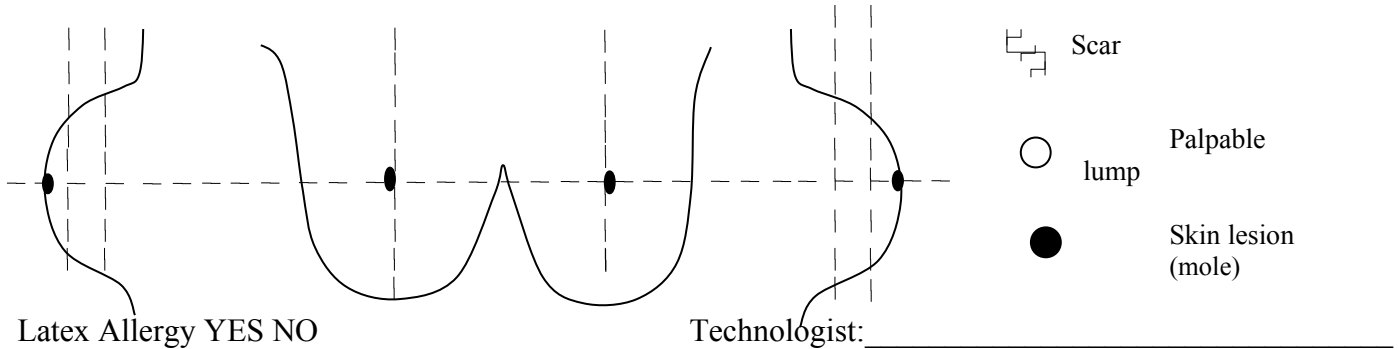
Are you currently breast feeding?

Do you have a family history of breast cancer?  
\_\_\_\_ Mother \_\_\_\_ Sister \_\_\_\_ Aunt \_\_\_\_ Daughter \_\_\_\_ Grandmother

Date of first period: \_\_\_\_\_ Date of last period: \_\_\_\_\_

**\*\* SECTION BELOW TO BE FILLED OUT BY TECHNOLOGIST / FOR OFFICE USE ONLY \*\***

|                  | YES                      | NO                       | Rt                       | Lt                       |                    |                        |            |
|------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------|------------------------|------------|
| Short Term F/U   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Calcifications     | Density                | Nodularity |
| Palp Mass        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Felt by patient    | Felt only by Physician |            |
| Nipple D/C       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Color of discharge | _____                  |            |
| Focal Tenderness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                    |                        |            |



I have reviewed & understand this page, and have no unanswered questions.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
Date

Patient Name Footer

**NOTICE OF PRIVACY PRACTICES**

**Dear TEPAS Breast Center Patient,**

Physicians have always protected the confidentiality of health information by sealing medical records away in file cabinets and refusing to reveal your information. Today, state and federal laws require health care organizations to protect this sensitive information.

The Federal government has published regulations designed to protect the privacy of your health information. This “privacy rule” or HIPAA, protects health information that is maintained by physicians, hospitals, other medical providers and health insurance plans.

This regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to a hospital, fill a prescription or send a claim to a health insurance plan, your health care provider has to consider the privacy regulations. All health information, including paper records, verbal communication and electronic records (email and electronic medical record), is protected by the privacy regulations.

The privacy rule also provides you with certain rights, such as the right to have access to your information. However, these rights are not unconditional. We take precautions in our office to ensure the safety of your health information, such as training our staff and implementing computer security measures.

It is sometimes necessary for our office to share your protected health information with other medical providers. In the event that our office refers you to another health care provider or facility for evaluation, testing or procedure, we are required to provide pertinent information regarding your care to that health care provider. It is also necessary, at times, for us to provide medical records to your health insurance plan in order for them to process a claim. We are not required to obtain your express permission prior to releasing records for this purpose.

A copy of The Notice of Privacy Practices is available to you in our office should you wish to read it. Please feel free to request a copy at your appointment. The Notice of Privacy Practices explains in detail how your confidential health information is handled by our office. It also describes how you can exercise your rights with regard to your protected health information.

The next few statements indicate ways that we may contact you or someone you designate with appointment and payment information.

I have reviewed & understand this page, and have no unanswered questions.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
Date

Patient Name Footer

**NOTICE OF PRIVACY PRACTICES (con't)**

Please read through the following statements and initial next to each one that you agree to.

\_\_\_\_\_ I give my permission for TEPAS Healthcare to leave messages on my answering machine regarding my scheduled appointments.

\_\_\_\_\_ I give my permission for TEPAS Healthcare to leave messages on my answering machine regarding payment information.

\_\_\_\_\_ I give my permission for TEPAS Healthcare to discuss my medical care with the following persons other than myself:

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

\_\_\_\_\_ I give my permission for TEPAS Healthcare to discuss payment information with the following persons other than myself:

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

I have reviewed & understand this page, and have no unanswered questions.

\_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Patient Name Footer