BREAST CENTER
of ACADIANA

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle _____

Address: _____ City: _____State: _____Zip Code: _____

DOB: _____ SSN: _____-____-_____ Gender: ☐ Female ☐ Male

Email: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Okay to leave message? ☐yes ☐ no Okay to leave message? ☐yes ☐ no Okay to leave message? ☐yes ☐ no

INSURANCE INFORMATION

(PLEASE FILL OUT IF THE PATIENT IS NOT THE POLICY HOLDER)

Primary Ins: _____ Policy # _____ Group #: _____

Policy Holder's Name: _____ DOB: _____ Relationship to Patient: _____

Secondary Ins: _____ Policy # _____ Group #: _____

Policy Holder's Name: _____ DOB: _____ Relationship to Patient: _____

RESPONSIBLE PARTY

(PLEASE FILL OUT IF THE PATIENT IS NOT THE POLICY HOLDER)

Name: _____ SSN: _____-____-_____ DOB: _____

Relationship to patient: _____ Phone: _____ Email: _____

*******PLEASE SIGN AND DATE*******

_____ _____

Signature of Patient/Patient's Legal Representative **Date**

_____

Printed Name of Patient/Patient's Legal Representative

For Office Use Only: ☐ DL Scanned ☐ Ins. Card Scanned ☐ Current address/phone ☐ Ref. Dr. Verified Initials: _____

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BREAST CANCER SCREENING: HISTORY AND RISK ASSESSMENT

Name: _____ DOB: _____ Age: _____ Date: _____

Referring Doctor: _____ If you would you like to have your breast imaging report sent to any other doctor(s) please list them here: _____

_____

1. Is this your first mammogram? YES NO If no, when and where was your last mammogram performed? _____

_____

2. Do you have any **new** problems related to your breasts since your last visit? YES NO If yes, please describe: _____

_____

3. Do you have breast implants? YES NO

4. Have you had a breast biopsy for something that was not cancer (benign)? YES NO

If yes, were you told that it was high-risk? YES NO Or that it could turn into cancer? YES NO

5. Have you ever had breast cancer? YES NO More than once? YES NO

6. Have you ever had ovarian cancer? YES NO

7. List family members, by relationship, who have had **breast** cancer and at what age they were diagnosed:

PRIMARY FAMILY (Mother, Father, Sister, Daughter etc.)	YOUR MOTHER'S SIDE (Grandparent, Aunt, Cousin)	YOUR FATHER'S SIDE (Grandparent, Aunt, Cousin)
_____ Age _____	_____ Age _____	_____ Age _____
_____ Age _____	_____ Age _____	_____ Age _____
_____ Age _____	_____ Age _____	_____ Age _____

8. List family members, by relationship, who have had **ovarian** cancer and at what age they were diagnosed:

PRIMARY FAMILY (Mother, Sister, Daughter)	YOUR MOTHER'S SIDE (Grandmother, Aunt, Cousin)	YOUR FATHER'S SIDE (Grandmother, Aunt, Cousin)
_____ Age _____	_____ Age _____	_____ Age _____
_____ Age _____	_____ Age _____	_____ Age _____

9. Have you or anyone in your family had a blood test for a breast cancer gene? YES NO If yes, how are they related to you and what were the results? _____

10. Have BOTH of your ovaries been removed? YES NO

11. Are you currently taking female hormones? YES NO If yes, for how long? _____

12. Have you stopped taking female hormones or changed hormone medication since your last mammogram? YES NO

13. Height _____ Weight _____

14. Have you lost weight since your last mammogram? YES NO If yes, how much? _____ pounds

15. Do you have an immune system condition or disease (lupus, rheumatoid arthritis, colitis, psoriasis, or other)? YES NO

16. Do you have any condition or disease which may cause enlarged lymph nodes? YES NO

17. Have you had a vaccination shot in the past 6 months? YES NO If yes, which arm? RIGHT LEFT

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Authorization to Share Protected Health Information

By signing below, I hereby authorize the RELEASE of all of my current and future breast imaging records to Breast Center of Acadiana to include: film, CD, surgery, pathology and final reports. Should I need my imaging records sent to another facility for treatment purposes, I give Breast Center of Acadiana my permission to release my records to include: film, CD, pathology and final reports. **This authorization will expire 3 years from the date of signature, unless revoked in writing by the Patient/Personal Representative before that date.**

Patient Name: _____ DOB: _____

Facility: _____ Date/Year of Mammogram: _____

Facility: _____ Date/Year of Mammogram: _____

Imaging records should be sent to:

Breast Center of Acadiana

107 Centre Sarcelle Blvd., Suite 701

Youngsville, LA 70592

Phone: (337) 504-5000 Fax: (337) 408-3921

_____ _____

Signature of Patient/Personal Representative **Date**

_____

Printed Name of Patient/Personal Representative

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INSURANCE AND PAYMENT POLICY, RELEASE AUTHORIZATIONS AND ACKNOWLEDGEMENT

The Breast Center of Acadiana is committed to making your experience with us as pleasant as possible. We want to make healthcare less stressful and more effective by clarifying financial responsibilities in advance. The following is a statement of our financial policy, which we ask that you read and sign where indicated.

INSURANCE AND PAYMENT POLICY

Your insurance policy is a contract between you and your insurance company. It is important that you contact your insurance prior to your visit to assure that we are a participating provider. Your insurance company will also be able to inform you if a referral is required or if precertification is needed prior to services being rendered. It is your responsibility to determine if services will be covered and if your deductible has been met.

We will bill most insurance carriers for you if proper information has been provided to us. If payment has not been made by the insurance company within 45 days, the unpaid balance will become your responsibility. All outstanding patient balances over 120 days from the original date of service without payment arrangements may be turned over to a collection agency. If Medicare is your primary insurance, we will file all claims and accept assignment for related services.

Co-payments and/or deductibles are due at the time of service. We accept payment in the forms of cash, check, Discover, Visa, Mastercard and American Express credit cards. There will be a $25 fee for all returned checks. Self-pay patients are required to pay at the time of service.

If you have any questions or concerns about billing, please call the billing office at (337)504-5000 (you may leave a message after business hours).

AUTHORIZATION TO RELEASE INFORMATION

I authorize Breast Center of Acadiana to furnish my protected health information to my insurance company concerning my illness and treatment for payment purposes. I hereby assign all benefits payable directly to Breast Center of Acadiana for services rendered. I understand that in the event my insurance denies this claim, I will be held financially responsible for all charges.

Patient Name _____ DOB_____

Signature of Patient/Guardian _____ Date _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO CERTAIN PERSONS

I authorize Breast Center of Acadiana to furnish my protected health information to the following individuals, all of whom are involved in my care for any purpose related to my treatment or the payment of my care. This agreement is in effect until otherwise revoked in writing by the Patient/Personal Representative.

Name _____Phone # _____

Name _____Phone # _____

Signature of Patient/Guardian_____ Date _____

ACKNOWLEDGEMENT RECEIPT OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Breast Center of Acadiana, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgement.

Signature of Patient/Guardian _____ Date_____