

BREAST IMAGING FORM

Rose Clinic, A Professional Medical Corp.
 530 Lomas Santa Fe Drive Suite B-1 Solana Beach, CA 92075
 Phone: 858-755-8955 Fax: 858-755-8959
 www.roseclinic.us

(Please Print)

Today's date:							
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		Occupation:		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()		
Street address, cont'd:			Work phone no.: ()		Cell phone no.: ()		
City:		State:		ZIP Code:		Email Address:	
How did you hear about Rose Clinic?							
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other	<input type="checkbox"/> Internet		
Other family members seen here:							

BREAST IMAGING QUESTIONS	
1. Date of last menstrual period: / /	
2. Date and location of last mammogram	
3. If your last mammogram was performed at another location, what were the results? Normal_____ Abnormal_____	
4. Has a physician examined your breasts within the last three months? Yes_____ No_____	
If yes, please specify: Normal Abnormal Right Left	
5. Are you feeling a new lump? Yes_____ No_____	
If yes, please specify: Right Left	
6. Are you feeling a new thickening? Yes_____ No_____	
If yes, please specify: Right Left	
7. Pain in one or both breasts? Yes_____ No_____	
If yes, please specify: Right Left	
8. Enlarged lymph nodes in armpits? Yes_____ No_____	
If yes, please specify: Right Left	
9. Nipple discharge? Yes_____ No_____	
If yes, please specify: Right Left	
10. Skin change around breast(s)? Yes_____ No_____	
If yes, please specify: Right Left	

11. Implants? Yes _____ No _____		
If yes, please specify: Right Left		
12. Reductions? Yes _____ No _____		
If yes, please specify: Right Left		
13. Benign breast biopsy(s)? Yes _____ No _____		
If yes, please specify: Right Left		
14. Lumpectomy for breast cancer? Yes _____ No _____		
If yes, please specify: Right Left		
15. Mastectomy? Yes _____ No _____		
If yes, please specify: Right Left		
16. History of radiation therapy to the breast, chest, head, or neck? Yes _____ No _____		
Type of Condition: _____ Number of Years Ago: _____		
17. Close family history of breast cancer (maternal or paternal)? Yes _____ No _____		
Please specify: Maternal Paternal		
Name:	Age of onset:	Number of breasts involved:
1.		
2.		
3.		
4.		
18. Family history of ovarian cancer? Yes _____ No _____		
Relationship: _____ Age of onset? _____		
19. Have you been tested for the breast cancer gene(s)? Yes _____ No _____		
If so: Positive Negative BRCA BRCA2		
20. Are you currently taking any medication(s) containing estrogen or progesterone? Yes _____ No _____		
If yes, what is the name of the medication(s)? _____		
How many years on this medication(s)? _____		
Please list all other current medications: _____		
Number of years on hormone replacement? _____		
21. Any serious medical conditions? Yes _____ No _____		
Please list: _____		

IF YOU HAVE BROUGHT PREVIOUS FILMS OR REPORTS WITH YOU, PLEASE GIVE THEM TO THE RECEPTIONIST BEFORE YOUR EXAM.

OUR FACILITY IS ACCREDITED BY THE AMERICAN COLLEGE OF RADIOLOGY AND THE FDA FOR ANALOG MAMMOGRAPHY.

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a Notice of Privacy Policies, from Jeanne Stryker MD detailing how my information may be used and disclosed as permitted under federal and state law. I understand that the Privacy Practices describes the personal information your office collect and how and when your office use or disclose that information. It also describes my rights as they relate to my protected health information. This notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations. If I do not accept this disclosure I understand that I must be notified when anything in my medical chart is going to be disclosed, to another physician or medical professional and that I must come in and sign for the medical release form of the items that are requested. I have listed below the following person(s) within my family or close friend(s) whom Dr. Jeanne Stryker can discuss my personal medical information with:

Name:	Relationship to patient:	Home phone no.:	Work phone no.:	Cell phone no.:
1.				
2.				
3.				
4.				
5.				

I accept my medical information may be disclosed under federal and state law.

I hereby authorize payment directly to Dr. Jeanne Stryker for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize Dr. Jeanne Stryker and/ or supplier in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guardian signature:	Date
Print Name:	Date
Reviewed by:	Date

PAYMENT INFORMATION

Payment is required in full for each visit. We are happy to provide you with coding information which you may submit to your insurance company for reimbursement. If you would like to keep a credit card on file for payments and or shipments please provide us with your credit card information.

Credit Card Number:	Expiration Date: / /	VISA, AMEX, MasterCard	Security Code:
Cardholder Name:	Signature:	Date: / /	

I authorize Dr. Jeanne Stryker to keep my signature on file and charge services and/or products on an ongoing basis. I understand this form is valid unless I cancel the authorization through written notice.

I have read the above billing information and give my consent for treatment at Rose Clinic.

WAIVER OF LIABILITY

Rose Clinic, A Professional Medical Corp. / Thermal MD, Inc.

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MEDICARE INFORMED CONSENT

In accordance with the Medicare Act, Section 1842(i), this letter is to advise you that Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a) (i) of the Medicare Act. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary," under Medicare program standards, Medicare will deny payment for that service. I believe that in your case, Medicare is likely to deny payment for the following reason (s):

Medicare usually does not pay for this service.

Medicare usually does not pay for this service/procedure for the reported condition.

Other (describe) _____

Rose Clinic/Thermal MD, will courtesy bill Medicare Part B as a non-participating provider. It is your responsibility to verify benefit coverage with Medicare Part B, prior to your visit to our office.

You are expected to prepay for services you receive at our office at the time of your appointment. Upon receipt of payment in full, Rose Clinic/ThermalMD will provide you with an insurance receipt. You may submit this receipt to Medicare Part B for reimbursement (in accordance with your health care benefit coverage).

You are directly responsible to Rose Clinic/ThermalMD for payment. This office does not accept responsibility for dispute, denied or unpaid claims.

PATIENT AGREEMENT

I have been notified by my physician that he or she believes that, in my case, Medicare is likely to deny payment for the service(s) identified above, for the reason stated. If Medicare denies payment, I agree to be personally and fully responsible for payment. I acknowledge that I am financially responsible for all charges received from the Rose Clinic/ThermalMD, including services not paid by Medicare Part B. I agree to pay for all cost and expenses incurred at the time of service.

Patient/Guardian signature:

Date

Print Name:

Date

Reviewed by:

Date