Clinic for Breast Care

J. Robert Lancaster, MD
Fellow, American
College of Surgeons

Caroline Schreeder, MD
Fellow, American
College of Surgeons

Dear Patient,

We would like to take this opportunity to thank you for choosing Huntsville Hospital Clinic for Breast Care for your healthcare needs and to welcome you to our office. We are pleased that you have chosen us to provide you with specialty medical services.

This letter is to confirm your appointment on _____.

We ask that you arrive at _____ so that you may be seen at your scheduled time.

If any recent breast imaging has been performed outside of the Huntsville area, we ask that you bring the imaging and films/CDs from the facility performed.

Please complete the enclosed forms and bring them with you on your appointment date, as well as your identification cards and insurance cards. You will also be asked to pay any co-pay or deductibles at the time of service.

If you are unable to keep this appointment or if you are going to be more than 15 minutes late, please call our office at (256)265-4560 as soon as possible. We will be happy to reschedule a more convenient time for you.

We look forward to seeing you and if you have any questions, please do not hesitate to call our office.

Sincerely,

Jennifer Stockman

Jennifer Stockman, R.N.
Clinical Practice Manager
Huntsville Hospital Clinic for Breast Care

201 Sivley Road, Ste. 320
Huntsville, AL 35801
o: (256) 265-4560
f: (256) 265-4565

Clinic for Breast Care

Patient Information:

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Male: _____ Female: _____ Single: _____ Married: _____ Divorced: _____ Widow:_____

Emergency Contact: _____ Phone: _____Relationship:_____

Email Address: _____

Would you like to have access to the patient portal? (Must provide email address) ____ YES _____NO

Employer Name: _____ Occupation:_____

Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Insurance Information:

Primary:

Insurance Name: _____

Address: _____ City: _____ State:_____ Zip:_____

Policy #:_____Group #:_____ Co-pay:_____

Policy Holder: _____ Relationship:_____

DOB: _____ Social Security #:_____ Phone #:_____

Secondary:

Insurance Name: _____

Address: _____City:_____ State: _____ Zip:_____

Policy #:_____ Group #:_____ Co-pay:_____

Policy Holder: _____ Relationship: _____

DOB: _____ Social Security #:_____ Phone #:_____

When applicable, I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and coinsurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs, or attorney's fees. I authorize HH Clinic for Breast Care to release information to insurance carriers and for insurance carrier's to release information to HH Clinic for Breast Care concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignments applies.

Signature of responsible person _____ Date: _____

Clinic for Breast Care

Patient Name: _____ DOB: _____
Why did you come to see the doctor today: _____
When did symptoms start: _____

Past Medical History:
Have you ever had or are currently being treated for: (Please check all that apply)

___Alcoholism/Substance abuse
___Kidney Disease
___Allergies
___Breast Disease
___Blood Clots
___Cancer: Type_____
___Bleeding Problems
___Diabetes
___Epilepsy/Seizures
___Heart Issue: _____
___Other_____
___Lung Disease
___High Blood Pressure
___Phlebitis
___Heart Disease
___Tuberculosis
___High Cholesterol
___Liver Disease
___Thyroid dysfunction
___GERD/Acid Reflux
___Sleep Apnea
___COPD

Have you ever been hospitalized? ____ Yes _____No
If yes, when, where, and what for?
_____
Have you ever had surgery? _____Yes _____N0
If yes, when, where, and what for?
_____
Are you a current or former smoker? ____YES ____NO About how many packs a day? _____
Have you quit smoking? ____YES ____NO If yes, what age did you stop? _____

Family History:
Please mark in boxes below for yourself and each family member who has condition:

	Lung Cancer	Colon Cancer	Cervical Cancer	Heart Disease	Stroke	Diabetes	Other (please list)
Mother							
Father							
M. Grandmother							
P. Grandmother							
M. Grandfather							
P. Grandfather							
Brother							
Sister							

Clinic for Breast Care

Patient Name: _____DOB:_____

Current Medications:

Please include dosage and how often you take the medication. (Skip if you brought list or bottles)

Do you currently take any blood thinners? YES NO

Name	Dosage	How many times per day?

Pharmacy Name: _____Phone:_____ Location: _____

Do we have permission to receive medication history on patient via electronic prescription? YES NO

Are you allergic to any medications? _____Yes ____No
If yes, list and explain reaction:
_____

Do you have an allergy to Latex? ____Yes ____No
Other Allergies:
_____

Signature of patient/guardian: _____ Date: _____

Clinic for Breast Care

Date: _____Name:_____

DOB: _____ Age: _____

Referring MD: _____ Race: _____ Imaging Facility: _____

Nature of breast complaint:
___Routine breast check
___Palpable breast mass
___Breast Injury
___Breast Pain
___Nipple discharge
___Skin changes, dimpling, puckering
___Abnormal mammogram or ultrasound
___Other

Personal History of breast cancer:
____NO
____YES
Date of diagnosis____/_____/____
Chemotherapy NO YES
Radiation NO YES
Hormonal Deprivation Therapy
NO YES

Treatment:
Surgical
Mastectomy NO YES
Which Breast Right Left Bilateral

Lumpectomy NO YES
Which Breast Right Left Bilateral

Lymph Node Removal NO YES
Which breast Right Left Bilateral
Removed_____

Other Surgical treatment_____

Medical Oncologist:_____

Radiation Oncologist:_____

Birth Control Pills:
Currently taking NO YES
Have you ever taken NO YES

Hormone Replacement Therapy:
Currently taking NO YES
Have you ever taken NO YES

Age at first menstrual period_____
Age at last menstrual period_____
Date of last menstrual period_____
Number of pregnancies_____
Age at first pregnancy_____
Bra Size_____

Previous breast biopsy/breast surgery:
_____NO _____YES
Which Breast _____Right_____Left
Procedure Date_____

Genetic History: (Please circle)
BRCA1 NO YES Unknown
BRCA2 NO YES Unknown
OTHER: _____

Family History Breast Cancer:
(List Age of Diagnosis)

	Breast	Ovarian
Mother		
Sister(s)		
Daughter(s)		
Maternal Grandmother		
Paternal Grandmother		
Aunts		

Clinic for Breast Care

201 SIVLEY ROAD, SUITE 320, HUNTSVILLE, AL 35801 PHONE: 256-265-4560 FAX: 256-265-4565

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ SS Number (Optional)_____

Date of Birth _____ Address _____

Phone Number (_____)_____Date(s) of Service_____

Chart Number_____
Provider _____

I authorize the use or disclosure of the above named individual's health information as described below:

1. Huntsville Hospital Physician's Network is authorized to make the disclosure.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

☐ All /Entire Record	☐ Pathology Report	☐ **Records Release Format**
☐ Visit/Encounter Notes	☐ Consultation Report	**(Choose one)**
☐ Laboratory Results	☐ Operative Report	☐ **e-delivery (HealthPort Connect)**
☐ X-Ray and Imaging Reports	☐ Immunization Record	☐ **CD**
☐ Problem list	☐ Drug and Alcohol Treatment	☐ **Paper**
☐ Medication List	☐ HIV/AIDS/STD Treatment	
☐ Allergies List	☐ Registration Record	
☐ EKG Report	☐ Other _____	

3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to, and used by, the following individual or organization:

   Name: _____

   Address: _____

5. For the purpose of _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:

   _____

   If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signing.

8. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

9. I understand that as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.

10. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

Or

I understand that if I refuse to sign this form, under specific conditions the organization can refuse:
Treatment Enrollment in the health plan Eligibility for benefits

_____ _____ _____
SIGNATURE DATE TIME

_____ _____ _____ _____
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT SIGNATURE OF WITNESS DATE TIME

For Office Use Only

Any portion of the record request found in paper chart? YES NO (Please circle one)

HH System Clinics Registration Update Sheet

Patient: _____ Date of Birth: _____ Fin #_____

----------**AUTHORIZATION TO CALL**---------

I authorize HH System Clinics to leave the following messages on my answering machine/voicemail:

_____ Reminder appointments calls

_____ Lab and/or Test results

----------**HH SYSTEM CLINICS ADVANCE DIRECTIVE POLICY**---------

In our practices we have decided that we will initiate resuscitative measures anytime they are needed.

----------**FINANCIAL FEES AND ASSISTANCE**---------

FINANCIAL FEES: I understand the following fee will be charged:

- A fee of $25 per form for completion of comprehensive forms. A fee will NOT be assessed for simple forms such as Work Excuse, School Excuse or application for Indigent Assistance for Medications.

FINANCIAL ASSISTANCE: I understand that financial assistance may be available for individual patients who are uninsured or who otherwise meet financial aid criteria. The hospital's overall ability to remain financially stable and provide essential health care services to all members of our community is dependent upon financial resources available to cover services provided to patients. My assistance in providing such information is necessary to determine possible financial aid available to me. If I am uninsured and need financial assistance, I may contact a Financial Counselor and make a request to see if I qualify at 256-265-9438.

----------**AUTHORIZATION OF TREATMENT**---------

I hereby consent and authorize my physician and/or Allied Health professional to render usual and customary medical/emergency treatment that they deem advisable and necessary. I also authorize HH System Clinics to electronically request my medication history if my pharmacy participates in electronic prescribing in order to assist the provider in prescribing necessary medication therapy.

----------**ASSIGNMENT OF BENEFITS, AGREEMENT AND GUARANTY** ----------

I authorize HH System Clinics to release any information regarding services rendered to me to third party payers in consideration of payment for my care or to other healthcare providers involved in my care. I understand payment of all insurance benefits, basic and major medical for this period of service must be made directly to HH System Clinics. If the check must be made out to me, I understand the check must be sent to this address: PN Billing P.O. Box 2705 Huntsville, AL 35804. I understand the HH System Clinics must collect for all charges not covered by insurance payments. Payment for all collection costs, securing, or attempting to collect and secure including reasonable attorney fees or Collection Agency fees, whether suit be necessary or otherwise is the financial responsibility of the patient and guardian. Patients who are considered a legal adult are financially responsible for all services rendered.

----------**HH HEALTH SYSTEM NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**----------

I acknowledge that a copy of the Notice of Privacy Practices for HH Health System has been made available to me. In connection with the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents. I understand that the most current version of the Notice will be posted with the Health System and on www.huntsvillehospital.org.

----------**EXPRESS PERMISSION TO CONTACT PATIENT BY CELL PHONE**----------

I agree in order for HH System Clinic to service my account or to collect monies I owe, HH System Clinics and/or our agents may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. HH System Clinics may also contact me by sending text messages

Patient: _____ Date of Birth: _____ Fin #_____

or emails, using any email address I provided. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable. I have read this disclosure and agree that HH System Clinics, its employees, and/or agents may contact me as described.

----------PHOTOGRAPHY CONSENT----------

I authorize photography for purposes of clinical treatment and staff education. I understand that any images or photographs will be used solely for these purposes and that I have the right to revoke this authorization or to refuse to be photographed at any time. I understand that only hospital authorized or issued equipment will be used to take photographs, and that my privacy and confidentiality will be maintained in the use of these images.

_____ Consent to Photography for Medical Treatment and Staff Education

_____ Decline Consent to Photography for Medical Treatment and Staff Education

Signature of Patient/Authorized Representative on behalf of patient: _____

Date: _____ _____ Time: _____

Printed Name of Person Authorized to sign for patient: _____

Basis of Authority to sign for Patient: _____

----------FOR USE BY HEALTH SYSTEM PERSONNEL ONLY ----------

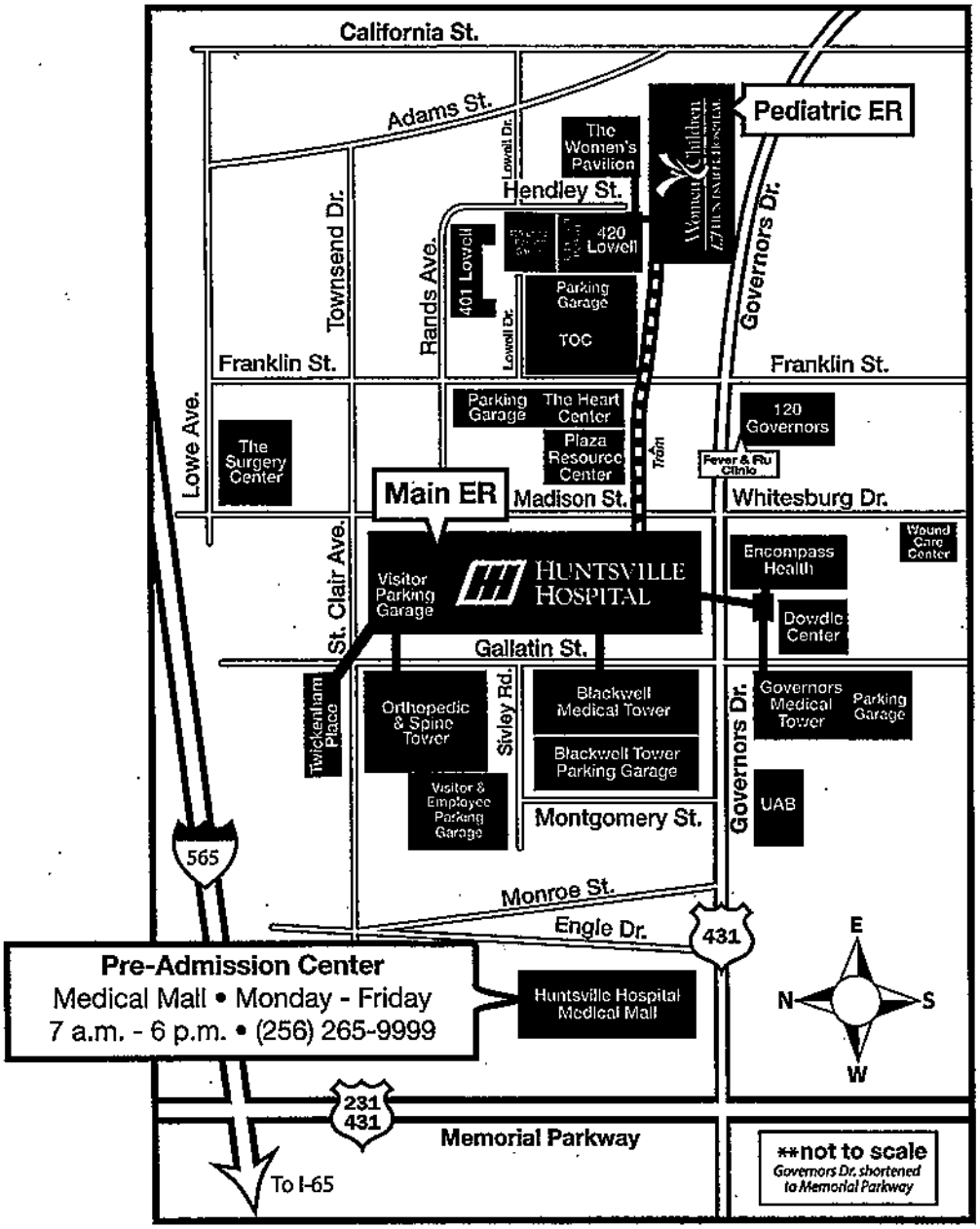
--------(Complete if patient Acknowledgment is not obtained) ----------

The patient was provided with a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An Acknowledgment was not obtained because _____

Witness/Employee Signature: _____ Employee ID: _____

Date _____ Time _____

HUNTSVILLE HOSPITAL / Medical District



MADISON HOSPITAL campus