

COMPREHENSIVE BREAST CENTER OF ARIZONA

Thank you for choosing the **Comprehensive Breast Center of Arizona**. We welcome you to our practice. We are committed to providing the finest personalized and professional care. **Please carefully read and sign the following statement of our financial policy prior to treatment.**

The patient or the guarantor is responsible for payment of services that are rendered if we are a preferred provider on your insurance plan. We will submit claims to your insurance company and make every attempt to collect with the information that you provide. **Please present your insurance card at each visit. You will be responsible for all co-pays, coinsurance, and deductibles on the day of service.**

IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS BEFORE THE VISIT. All insurance information including prior authorizations must be provided at the time of service and before you are seen. It is your responsibility to notify our office if there is a change in your insurance coverage, residence or phone number.

You are ultimately responsible for payment of services rendered if your insurance carrier does not pay for any reason. Upon review of your account at 60 days past your original bill submission date the balance of your account now falls to your full financial responsibility. If you are unclear of your insurance benefits, you will need to contact your insurance carrier for clarification of coverage. If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen. We accept cash, checks, debit cards, VISA, and MasterCard. There will be a \$30.00 service charge for returned checks.

Delinquent accounts over 90 days will be placed for collections with a third party collection agency, and a fee of 33% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed, such as court costs, attorney fee, and all other expenses.

I have read the above and understand the Financial Policy and agree to abide by the terms.

PRINTED NAME

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

DATE

COMPREHENSIVE BREAST CENTER OF ARIZONA

Films

I understand that **Comprehensive Breast Center of Arizona** is not responsible for any films. They do not store films in this office. Do not have films mailed or dropped off at this site. Please hand-carry your films to your appointment. Do not have films couriered to this office, as this service can be unreliable. I will be responsible for returning my films to the original radiology facility.

Assignment of Benefits Form

I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier (s) including Medicare, private insurance and any other health/medical plan to issue payment check (s) directly to **Comprehensive Breast Center of Arizona**. Dr. Moorthy/Dr. Cox for medical services rendered to me and /or my department regardless of my insurance benefits. I understand that I am responsible for any amount not covered by my insurance.

Authorization to Release Information

I authorize Dr. Moorthy/Dr. Cox to release any information necessary to insurance carriers regarding my illness and treatment: (2) process insurance claims generated in the course of treatment (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

Patient Acknowledgement of HIPAA Notice

I understand that my/the patient's health information is private and confidential. I understand that the **Comprehensive Breast Center of Arizona** works hard to protect my/the patient's privacy and preserve the confidentiality of my health information.

I understand that the **Comprehensive Breast Center of Arizona** may use and disclose the patient's health information to provide treatment to me, to handle billing and payment and to take care of other healthcare operations. In general, there will be no other uses and discloses of this information unless I permit it. **Comprehensive Breast Center of Arizona** has a detailed document called the "Notice of Privacy Practices" posted in their office. It contains detailed information about how they may use and disclose patient health information and I acknowledge that I can receive a copy of this "Notice" for my own records.

Comprehensive Breast Center of Arizona may update the "Notice of Privacy Practices". If I ask, I will be provided with the most current "Notice of Privacy Practices". My signature below indicates that a current copy of **Comprehensive Breast Center of Arizona's** "Notice of Privacy Practices" has been made available to me.

Patient/Legally Authorized Signature

Date/Time

I give permission to **Comprehensive Breast Center of Arizona** to release my health information to the following person(s): _____

I give permission to have my films and pathology obtained by Banner Thunderbird for purposes of discussion at Breast Tumor Board.

COMPREHENSIVE BREAST CENTER OF ARIZONA

Name _____ DOB ____/____/____

Who referred you to our office? _____

Primary Care Physician _____

Main Complaint _____

NEW PATIENT HISTORY

REVIEW OF SYSTEMS: (Check those that apply)

Breast

____breast mass ____breast cancer ____breast pain ____discharge ____swelling
____nipple retraction ____skin dimpling ____fissured nipple ____breast redness

General

____fatigue ____headaches ____obesity ____weight gain ____weight loss
____fainting ____night sweat ____bone pain

Heart & Circulation

____cardiac murmur ____chest pain ____chest pressure ____palpitations
____swelling in legs ____irregular heartbeat ____shortness of breath
____history of heart attack ____high blood pressure

Breathing & Lungs

____wheezing ____shortness of breath ____chronic cough ____blood in sputum
____bronchitis ____pneumonia ____asthma ____abnormal chest x-ray

Women

____menstrual pain ____urinary frequency ____urinary incontinence
____urinary retention/hesitancy ____urinary urgency ____vaginal discharge
____heavy periods ____no periods

Digestion & Intestine

____change in bowel habits ____constipation ____gas & bloating ____hemorrhoids
____indigestion ____rectal bleeding ____jaundice ____abdominal pain

Blood System

____night sweats ____bleeding spontaneously ____easy bleeding
____blood transfusions

Nerves, Movement & Brain

____migraine ____spasms/spasticity ____seizures ____history of stroke
____numbness

Immune System

____rash ____hepatitis ____HIV

Hormone System

____diabetes ____thyroid disease

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LIST ALL CURRENT MEDICATIONS:

Medication name	Dose	Frequency	Taking for what illness

Do you take Aspirin on a daily basis? (including baby aspirin) ___ yes ___no

If you have had an allergic reaction to any medication; please list the medication and reaction below. Include any allergies to betadine, or latex.

PAST SURGICAL HISTORY:

Operation	Date
Operation	Date
Operation	Date

Age of 1st period _____ Date of Last Menstrual Period _____
 Age of first full term pregnancy _____ Number of pregnancies _____
 Number of live births _____ Number of abortions _____ Number of miscarriages _____
 Years of oral contraceptive use _____ Years of hormone replacement _____
 Years of Fertility Treatments _____
 Did you breast feed? ___yes ___no

Do you smoke? ___yes ___no If yes, how many # _____years _____packs/day
 Do you consume alcohol? ___yes ___no If yes, how much? _____
 Cups of coffee/day_____

Have you ever been diagnosed with or treated for (please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Cancer of any type |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Blood clot in legs or lungs |
| <input type="checkbox"/> Emphysema/Asthma | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Stroke, ministroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Bleeding problems |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Steroid use | <input type="checkbox"/> Condition that requires blood thinners |
| <input type="checkbox"/> Pacemaker | |

FAMILY HISTORY:

Do you have any Ashkenazi Jewish Heritage (Eastern European descent) Yes No

Please indicate relationship, age and diagnosis

- Breast Cancer _____
- Ovarian Cancer _____
- Colon Cancer _____
- Uterine Cancer _____
- Heart Disease _____
- Malignant Melanoma _____
- Pancreatic Cancer _____