

**THE BREAST CARE CENTER, PC  
PATIENT REGISTRATION FORM**

ACCT# \_\_\_\_\_

**BILLING/GUARANTOR INFORMATION**

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

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

**PATIENT INFORMATION**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Emergency Phone: ( ) \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_ Martial Status: \_\_\_\_\_

Social Security No. \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Maiden/Previous Name: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE:** \_\_\_\_\_

Group No: \_\_\_\_\_ Policy No: \_\_\_\_\_ Copay Amt: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_

Group No: \_\_\_\_\_ Policy No: \_\_\_\_\_ Copay Amt: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_



Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have with insurer).

I directly assign all medical/surgical benefits to The Breast Care Center, P.C. and understand that I am financially responsible for all charges not covered by insurances. I hereby authorize The Breast Care Center, P.C. to release all information necessary to secure the payment of benefits. In the event of non-payment, either by insurance or myself, I agree to pay all costs of collection, including a reasonable attorney's fee in the event it is necessary to employ an attorney to enforce any provision of this contract.

In order to help control the cost of billing, we request payment be made for all office services at the conclusion of your visit unless other arrangements have been made prior to services being rendered.

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Signature of Patient or Legal Representative

Date

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other commercial insurance company, and information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

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Signature of Patient or Legal Representative

Date

\_\_\_\_\_ I acknowledge receipt of the Notice of Privacy Practices form which details how Protected Health Information may be used and disclosed, and how I may access that information.

PATIENTS NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

DATE \_\_\_\_\_

ACCT # \_\_\_\_\_

**DO YOU HAVE OR HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING:**

Yes No When

Yes No When

**I. Gastro-Intestinal**

Internist you have seen: \_\_\_\_\_

Ulcers	_____	_____	_____
Jaundice	_____	_____	_____
Hepatitis	_____	_____	_____
Vomiting Blood	_____	_____	_____
Blood In Stool	_____	_____	_____
Hemorrhoids Or Rectal Bleeding	_____	_____	_____
Unexplained Diarrhea	_____	_____	_____
Constipation	_____	_____	_____
Unexplained Weight Loss	_____	_____	_____
Gallbladder Trouble	_____	_____	_____
Difficulty In Swallowing	_____	_____	_____
Indigestion And/Or Heartburn	_____	_____	_____
Regurgitation Of Food Or Liquid	_____	_____	_____

**II. Urologic**

Urologist you have seen: \_\_\_\_\_

Kidney Infections	_____	_____	_____
Blood In Urine	_____	_____	_____
Prostate Trouble	_____	_____	_____
Kidney Stones*	_____	_____	_____

**III. Female**

Gynecologist you have seen: \_\_\_\_\_

Irregular Menstrual Periods	_____	_____	_____
Bleeding After Intercourse	_____	_____	_____
Painful Intercourse	_____	_____	_____
Loss Of Urine With Straining	_____	_____	_____
Vaginal Bleeding After Menopause	_____	_____	_____
Lumps In Breast L R	_____	_____	_____
Mastitis L R	_____	_____	_____
Nipple Discharge L R	_____	_____	_____
Taking Birth Control Pills	_____	_____	_____
Taking Hormone Pills	_____	_____	_____
Number of Pregnancies _____ Miscarriages _____			
Date of last menstrual period _____			
Ages of Children _____			

**IV. Heart And Lungs**

Cardiologist you have seen: \_\_\_\_\_

Heart Attacks	_____	_____	_____
Coughing Blood	_____	_____	_____
Pneumonia	_____	_____	_____
Chest Pain with Exertion	_____	_____	_____
Irregular Heart Breath	_____	_____	_____
Shortness of Breath with Exertion	_____	_____	_____
High Blood Pressure	_____	_____	_____
Low Blood Pressure	_____	_____	_____

**V. Vascular**

Phlebitis	_____	_____	_____
Leg Pain with Walking	_____	_____	_____
Impotency	_____	_____	_____
Night Leg Cramps	_____	_____	_____
Swollen Legs & Ankles	_____	_____	_____
Paralysis	_____	_____	_____
Strokes	_____	_____	_____
Convulsions	_____	_____	_____
Unconsciousness	_____	_____	_____

**VI. Miscellaneous**

Arthritis	_____	_____	_____
Cancer	_____	_____	_____
Thyroid Disease	_____	_____	_____
Diabetes	_____	_____	_____
Enlarged Lymph Glands	_____	_____	_____
Anemia	_____	_____	_____
Hernia	_____	_____	_____
Other Diseases: _____			

1. Age \_\_\_\_\_
2. Ages first menses \_\_\_\_\_
3. Age first live birth (0 = None, if age < 13, enter 13) \_\_\_\_\_
4. Number of mother/sister(s)/ daughters(s) with breast cancer \_\_\_\_\_
5. Number previous breast biopsies \_\_\_\_\_
6. \_\_\_\_\_



## The Breast Care Center, PC

### **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Please direct questions about this notice to the Office Manager at (256) 265-7966

**EFFECTIVE DATE: January 1, 2004**

#### **WHO WILL FOLLOW THIS NOTICE:**

- Any health care professional authorized to enter information into your medical record.
- All employees, staff, and contract staff

#### **OUR PLEDGE REGARDING MEDICAL INFORMATION:**

We understand that medical and billing information about you and your health is personal and confidential. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Breast Care Center, PC. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Breast Care Center, PC, and any records contained within your medical and billing record here. Non Breast Care Center, PC providers may have different policies or notices regarding their use and disclosure of your medical information created in their office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of this information.

#### **We are required by law to:**

- Make sure that medical and billing information that identifies you is kept private;
- Notify you of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

#### **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.**

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other health service organizations who are involved in taking care of you. Also, we may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the Breast Care Center, PC who may be involved in your continued care, such as family members, nursing service providers or others we use to provide services that are part of your care.
- **For Payment.** We may use and disclose medical information about you so that the treatment and services you receive at the Breast Care Center may be billed to and payment may be collected from you, an insurance company, a third party or a State or Federal Program. For example, we may need to give your health plan information about surgery you received at the hospital so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or care at the Breast Care Center PC.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member that you indicate is involved in your care or the payment for your care unless you object in whole or in part. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of your information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose information for research, the project will have been approved through this research approval process. We may, however, disclose medical information about you to people preparing to conduct a research project. For example, this information may help researchers look for patients with specific medical needs. This information will remain within the institution. We will ask for your specific permission to give a researcher your name, address or other information that reveals who you are. In rare cases, your permission may be waived as directed by federal, state, and local law.
- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to help prevent the threat.

#### **YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.**

- **Right to Inspect and Copy.** You have the right to inspect and have copied information that is considered part of your medical and billing records that may be used to make decisions about your care. **To inspect and have copied medical information about you,** you must submit your request in writing to the Breast Care Center, PC, Office Manager. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We will respond within 30 days of receiving your written request. We may deny your request to inspect and copy in certain very limited circumstances. In certain circumstances, if you are denied access to your information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Breast Care Center, PC, physician will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Correct or Update.** For as long as your protected health information is kept by or for the Breast Care Center, PC you have the right to request a correction if you feel that this information is incorrect or incomplete. To request a correction or update, your request must be made in writing with a reason to support the request and submitted to the Office Manager of the Breast Care Center, PC. We will respond within 60 days of receiving your written request. We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the information kept by or for the Breast Care Center, PC; is not part of the information which you would be permitted to inspect and have copied or is accurate and complete.

Any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.

- **Right to a List of Disclosures We Have Made About You.** You have the right to request an accounting of the disclosures we made of your medical and billing information except for disclosures made for treatment, payment and Breast Care Center, PC operations as defined above. We are not obligated to list all disclosures made about you. To request this list of disclosures, you must submit your request in writing to the Breast Care Center, PC, Office Manager. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. We will charge you for the costs of providing the list. We will notify you of costs involved and you may alter your request before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical and billing information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request restrictions regarding your care, you must make your request directly to those who are caring for you. To request restrictions regarding payment, you must make your restriction request known at the time of your registration to the doctor's office or by calling the Office Manager. Any other restrictions must be in writing to the Office Manager. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request at the time of registration at the doctor's office or by calling the Office Manager. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**CHANGES TO THIS NOTICE.** We reserve the right to change the terms of this notice and make the revised or changed notice effective for all protected health information we maintain. We will post copies of the current notice in the waiting area of the Breast Care Center, PC where you receive care. The effective date of the notice is contained on the first page. In addition, each time you register at the Breast Care Center, PC we will offer you a copy of the current notice in effect.

**COMPLAINTS.** You will not be penalized for filing a complaint. If you believe your privacy rights have been violated, you may file a complaint with the Breast Care Center, PC, Office Manager or Secretary of the Federal Department of Health and Human Services (DHHS).

■ To file a complaint with the Breast Care Center, PC, please contact the Office Manager at (256) 265-7966. All complaints must be submitted in writing to:

The Breast Care Center, PC  
ATTN: Office Manager  
910 Adams Street, Ste. 130  
Huntsville, AL 35801

■ To file a complaint with the DHHS, you must file in writing (electronic or paper), within 180 days of when you knew, or should have known of the problem. Send your complaint to:

DHHS Regional Manager, Office for Civil Rights  
U.S. Department of Health and Human Services Government Center  
J.F. Kennedy Federal Building - Room 1875  
Boston, Massachusetts 02203  
Voice phone (617) 565-1340  
FAX (617) 565-3809

**OTHER USES OF MEDICAL INFORMATION.** Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose medical information about you, you may revoke it, in writing, at any time. If you revoke it, we will no longer use or disclose medical information about you for the reasons covered by your written authorization, unless required by law. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.