PATIENT INFORMATION

Saint Thomas Breast Specialists

P: 615.284.5887 **F:** 615.284.5889 **SaintThomasDoctors**.com

PATIENT INFORMATION (PLEASE PRINT)

Name: ______________________________ Date of Birth: ____________ Age: ________
(LAST) (FIRST) (MI)

Address: ____
(STREET/CITY/STATE/ZIP)

Home Phone: ______________________ Cell Phone: ______________________

Email: ____

Marital Status (Circle One): Married Single Widowed/Divorced/Minor/Child Partnered

Social Security#: ______________ Employer: ______________ Work Phone: ____________

Work Address: ____
(STREET/CITY/STATE/ZIP)

Referring Physician: ______________________ Phone: ______________

Emergency Contact: ______________________ Phone: ______________

Address: ______________________ Relationship: ______________
(STREET/CITY/STATE/ZIP)

Responsible Party Name: ______________________ Relationship: ______________

Address: ______________________ Phone: ______________
(STREET/CITY/STATE/ZIP)

Employer Name: ______________________ Employer Phone: ______________

INSURANCE INFORMATION (PLEASE PRINT)

POLICY 1	POLICY 2
Name:	Name:
Address:	Address:
Name of Insured:	Name of Insured:
Relationship to Insured:	Relationship to Insured:
Gender of Insured (circle one): Male Female	Gender of Insured (circle one): Male Female
Insured Date of Birth:	Insured Date of Birth:
Insured Social Security #:	Insured Social Security #:
Policy #:	Policy #:
Group #:	Group #:

AUTHORIZATION (SIGN BELOW)

I hereby authorize the release of any medical information necessary to process insurance claims and further authorize payment of medical benefits to my physician when he/she files a medical claim for services rendered. I understand that co-pays are due in full at the time of my visit. I acknowledge that if I am unable to meet my financial obligations at the time of my appointment or procedure, it may be necessary to reschedule my appointment.

Patient Name: ______________________________ DOB: ______________

Signature: ______________________________ Date: ______________

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RELEASE OF INFORMATION (PLEASE PRINT)

Name: ______________________________ Today's Date: ______________
(LAST) (FIRST) (MI)

I, ____________________________________ , hereby authorize the Saint Thomas Breast Specialists (STBS) Staff and Agents to disclose, release, or obtain records, including medical imaging and test results, as needed to safely manage my breast health-care. I also authorize facilities, where STBS Staff perform procedures or order tests (including the breast MRI facilities at Specialty MRI and Vanderbilt MRI) to disclose, release or obtain my health records (including medical imaging and test results) as needed to complete imaging studies, tests or procedures ordered by STBS Staff.

X ______________________________ ______________________ ______________
(Signature of Patient or Personal Representative) (Patient Date of Birth) (Date)

This authorization shall be in force and effect for five (5) years.

YOUR RIGHT TO TERMINATE OR REVOKE AUTHORIZATION

You may revoke or terminate this authorization by submitting a written notice to the Saint Thomas Breast Specialists. Please contact the Privacy Officer or Privacy Contact in writing to terminate this authorization at:

Saint Thomas Breast Specialists
300 20"' Ave. North, Suite 601
Nashville, TN 37203

POTENTIAL FOR RE-DISCLOSURE

Information that is released under this authorization may be released again by the person or organization to which it is sent. It may not be protected under the federal privacy regulations.

I understand that, as set forth in the Provider's Privacy Notice, I have the right to inspect or copy the protected health information to be used and disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights). I understand I need to make this request in writing to the Privacy Officer.

I understand the quality of my treatment and care at the Saint Thomas Breast Specialists will not be jeopardized whether I provide the requested authorization.

X ______________________________ ______________
(Signature of Patient or Personal Representative) (Date)

______________________________ ______________
(Printed Name of Patient, or Personal Representative) (Patient Date of Birth)

______________________________ ______________
(Witness) (Date)

PATIENT HISTORY

Saint Thomas Breast Specialists

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PATIENT HISTORY (PLEASE PRINT)

Name: ____ Today's Date: ____________________
(LAST) (FIRST) (MI)

Previous operations and approximate dates ____

____

Approximate dates and reasons for hospital admissions not involving surgery (including childbirth): ____________

____

FAMILY HISTORY:

Has anyone in your family had any of the following?

If "yes", indicate that person's relationship to you, otherwise, list "no"::

High Blood Pressure ______________________________ Heart Attack __________________________

Heart Failure ___________________________________ Stroke _______________________________

Diabetes. ______________________________________ Any illness that runs in the family? ____________

____

Cancer: Who and What kind? ____

____

Do you smoke? Y/N If yes: Packs per day?_________ How long? __________ If quit: How long ago? __________

Servings per day: Coffee ______________ Tea______________ Cola _____________ Chocolate ____________

Present alcohol use: _____________________________ Past alcohol use: ___________________________

Have you recently had any of the following? (Please Circle "Y" for Yes or "N" for No)

Constitutional: Weight loss or gain? **Y/N** (if so, how much) __________ Cold or flu? **Y/N** Fatigue/Lethargy? **Y/N**

Neurological: Blindness? **Y/N** Fainting? **Y/N** Weakness on one side? **Y/N** Seizures? **Y/N**

Respiratory: Smothering? **Y/N** Shortness of breath? **Y/N** Persistent cough? **Y/N** Difficulty Breathing Deeply? **Y/N**

Cardiovascular: Shortness of breath lying flat? **Y/N** Chest pain like a heart attack? **Y/N** Swelling? **Y/N**

Gastrointestinal: Indigestion? **Y/N** Vomiting? **Y/N** Diarrhea? **Y/N** Blood in stool? **Y/N** Constipation? **Y/N**

Urinary: Trouble passing urine? **Y/N** Frequency______________ Urgency ______________ Pain? **Y/N**

Musculoskeletal: Shoulder, Back, Neck or Chest Pain.? **Y/N** Arthritis? **Y/N** Muscular or Joint Pain/Tightness? **Y/N**

Stiffness? **Y/N** Limited Range of Motion? **Y/N** Weakness? **Y/N** Difficulty in Daily Tasks (dressing, etc.)? **Y/N**

Skin Trouble: Y/N Explain: ________________________________ **Lymphatic:** Swelling in glands: **Y/N**

Psychiatric: Depression? **Y/N** Anxiety? **Y/N** Suicidal thoughts? **Y/N**

Endocrine: Excessive thirst or urination.? **Y/N** Feeling too hot or cold? **Y/N**

BREAST HEALTH INFORMATION:

Please list any previous breast problems or breast surgery.

____

____

Saint Thomas Breast Specialists

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PATIENT HISTORY (PLEASE PRINT)

Name: ____ Today's Date: ____________________
(LAST) (FIRST) (MI)

Date of Birth: ________________________ Age: _________ Occupation: ________________________

For what problem did you come to the doctor today? ______________________________________

First noticed when? ___________ Location: ______________ Severity or size: ____________________

Recent changes _________________________ Any associated symptoms __________________________

Any associated possible causes (stress, medicines, menstrual cycle) _____________________________

Had a similar problem before (note when and how resolved) _________________________________

Doctor who sent you here ____

Who is your PCP/Family Doctor? ________________________ OB/Gyn? ________________________

List medicines you cannot take because of *ALLERGY* or side effects (please note type of reaction): ___________

____

List medicines you do take (include aspirin, over-the-counter, supplements): ____________________

____

MEDICAL PROBLEMS YOU HAVE: (PLEASE CIRCLE ALL THAT APPLY)

			Arthritis
Diabetes	Kidney Problems	HIV or AIDS	Heart Problems
Excessive Bleeding	Hepatitis or Jaundice	Asthma	Heart Attack (MI)
Stroke	Thyroid Disease	TB	Heart Surgery
Anemia	Ulcers	Emphysema	High Blood Pressure
Clotting or bleeding disorder	Autoimmune Disorder	Depression/Anxiety	High Cholesterol

Cancer: What kind? ____

Age menstrual periods began: ______ Date of last menstrual period: ___________ Number of children ________

How many times have you been pregnant? ____________ Age at delivery of first live child ______________

Have you ever taken birth control pills? **Y/N** Approximate dates: ____________________

Have you ever taken hormones? **Y/N** What kind? ______________ Dose? __________ How long? ________

Have you ever had a Breast Biopsy? **Y/N** If yes, when? ____________ Outcome? ________________

Have you had your Uterus removed? **Y/N** If yes, when? ____________ Outcome? ________________

Have you had your Ovaries removed? **Y/N** If yes, when? ____________ Outcome? ________________

Race (circle one): African-American White Asian Hispanic Native American Other

Saint Thomas
Breast Specialists

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FAMILY HISTORY QUESTIONNAIRE: For Breast & Ovarian Cancer

Name: ____
(LAST) (FIRST) (MI)

Physician: ______________________________ Date: ______________

Please list Physicians/providers that you would like your reports sent to:

Dr. ______________________________ Phone: ______________

Dr. ______________________________ Phone: ______________

Please place a checkmark in the boxes below for yourself and for each family member who has had breast or ovarian cancer as indicated:

	BREAST CANCER BEFORE AGE 50	BREAST CANCER AFTER AGE 50	OVARIAN CANCER AT ANY AGE
Self			
Mother			
Sister			
Daughter			
MOTHERS SIDE			
Grandmother			
Aunts			
Cousins			
FATHERS SIDE			
Grandmother			
Aunts			
Cousins			

Please list any Males, in your family, with Breast Cancer at any age:

BREAST CANCER BEFORE AGE 50	BREAST CANCER AFTER AGE 50

PHARMACY INFORMATION

Saint Thomas Breast Specialists

P: 615.284.5887 **F:** 615.284.5889 **SaintThomasDoctors**.com

For future prescriptions, please fill out the following.

Name: ____
(LAST) (FIRST) (MI)

Pharmacy Name: ____

Pharmacy Location: ____

Pharmacy Phone: ___( )__________ — ______________

Saint Thomas Breast Specialists

FINANCIAL POLICY

P: 615.284.5887 **F:** 615.284.5889 **SaintThomasDoctors**.com

CO-PAYS:

I understand that co-pays are due in full-at the time of my visit. Saint Thomas Breast Specialists accepts Cash, Check, Master Card, Visa and American Express. There is a $25 fee for returned checks.

PATIENT "OUTSTANDING" BALANCES:

I understand it is my responsible to pay any outstanding balances as determined by my Insurance Plan.

COLLECTIONS:

In the event of default, the patient or responsible party agrees to pay all cost of collection, including attorney fees. Collections and contingent fees to be added and collected by the collection agency and/or attorney.

REFERRALS:

It is my understanding that if my Insurance Plan requires a referral that it is my responsibility to obtain one prior to every office visit.

OUT OF NETWORK:

I understand that if I choose a provider outside of my Insurance Network, the Plan will pay at a lesser benefit and I am responsible to pay the difference.

PROCEDURE/SURGERY DEPOSITS:

I understand that I may be required to pay a deposit prior to my procedure. (This deposit will be applied to my balance.)

PRECERTIFICATION OF MY PROCEDURE:

I understand that (name of practice) will make every effort to obtain prior approval from my Insurance Plan. Nevertheless, it is my responsibility to be sure this is done.

I acknowledge that if I am unable to meet my financial obligations at the time of my appointment or procedure, it may be necessary to reschedule my appointment.

I have read and understand the Financial Policy of the Tennessee Breast Specialists.

______________________________ ______________________________
Patient Name Date of Birth

X ______________________________ ______________________________
Patient Signature Date

Saint Thomas Breast Specialists

P: 615.284.5887 **F:** 615.284.5889 **SaintThomasDoctors**.com

SAINT THOMAS BREAST SPECIALISTS:

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and discussed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI), to carry out Treatment, Payment, or Health Care Operations (TPO), and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and 'treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Another example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. HIPAA Notice of Privacy Practices

Healthcare Operation

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students who see patients at our office. In addition, we may use a sign-in-sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your upcoming appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law. Public Health issues as required by Law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement: Coroners, Funeral Directors, and Organ Donation. Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken in action in reliance on the use or disclosure indicated in the authorization.

The Patient's Rights

The following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in a reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional, outside of the Saint Thomas Breast Specialists practice. You have the right to request to receive confidential communications from us by alternative means or at alternative location(s}. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically. You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and we will provide you a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us, you may file a complaint with us by notifying our Management team of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form please as to speak with our HIPAA compliance Officer in person by phone at our main phone number 284-5887.

Saint Thomas Breast Specialists

P: 615.284.5887 **F:** 615.284.5889 **SaintThomasDoctors**.com

SIGNATURE PAGE — OFFICE COPY

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.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI), to carry out Treatment, Payment, or Health Care Operations (TPO), and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Treatment

Payment

Healthcare Operation

Other Permitted and Required Uses and Disclosures

You may revoke this authorization

The Patient's Rights

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Management team of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form please as to speak with our HIP AA compliance Officer in person by phone at our main phone number 615.284.5887.

Please sign below to acknowledge that you have received this Notice of our Privacy Practices and return to check-in staff.

____

Patient Name

X ____ ____________________

Patient Signature Date

USE/DISCLOSURE OF PROTECTED INFORMATION

Saint Thomas Breast Specialists

P: 615.284.5887 **F:** 615.284.5889 **SaintThomasDoctors**.com

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1 By signing this Authorization, I authorize Tennessee Breast Specialists to disclose protected health information to the following individual(s)for the purpose of keeping them informed about my condition and treatment, and I understand that these disclosures are in addition to those disclosures described in the Notice of Privacy Practices:

Name: ______________________________ Relationship: ______________________

Method of Communication: ____

2 May we contact you regarding your protected health information, health status, appointments, and test results?

_______ Yes, you may contact me by email, my address is ______________________________

_______ No, do not contact me by email for this purpose.

_______ Yes you may contact me by phone, my daytime phone numbers are:

( ) __________ – ______________________ ( ) __________ – ______________________

Can we leave a message regarding your protected health information at the numbers you provided above?

______________ Yes ______________ No

_______ No, do not contact me by phone for this purpose.

3 May we send you newsletters and other· marketing information by email?

_______ Yes, please use the following email address: ______________________________

_______ No, I do not want to be sent newsletters or other marketing information.

I understand that I do not have to sign this Authorization In order to receive treatment and revocation of any authorizations will not affect my ability to continue receiving treatment.

I understand that once my health information is disclosed to a third party, that party may disclose my information to other parties and any re-disclosures of my health information by a third party ma~ no longer be protected under federal or state privacy laws.

I understand that protected health information may include information relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection.

I understand that this Authorization will remain in effect until I am terminated in writing as a patient of this practice or until I submit a written request to revoke this Authorization to the address above or send an email to the address at ‘the top of this Authorization. However, any disclosure that occurred prior to the date of the revocation will not be affected.

I understand that no protected health information (other than as outlined by the Health Insurance Portability and Accountability Act and in the Practice Notice of Privacy Practices, a copy of which I have received) can be released to anyone, including spouses, parents, other family members, significant others or friends without this Authorization.

Patient Signature: ______________________________ Date: ______________

Printed Patient Name:: ______________________________ DOB:: ______________

Signature of Patient Representative: ______________________________ Date: ______________

Printed Name of Patient Representative: ______________________ Relationship: ______________