Acknowledgement and Consent

austin BREAST IMAGING
In Partnership with rose imaging SPECIALISTS

_____ *Initials*

1. I understand that I have the right to choose the provider of my health care services and I have chosen Austin Breast Imaging.

_____ *Initials*

2. I understand that I have received a copy of the Health Insurance Portability and Accountability Act (HIPAA) from this facility concerning how the use and disclosure of Protected Health Information is handled by the practice.

_____ *Initials*

3. I understand that questions related to family history and risk factors may be obtained and used to calculate my individual risk of breast cancer.

_____ *Initials*

4. Austin Breast Imaging is licensed by the Texas Department of Health. Complaints against this facility may be directed by telephone to: 888.973.0022 or in writing to: Texas Department of Health, Health Facility Licensure and Certification, 1100 West 49th Street, Austin, Texas 78756.

_____ *Initials*

5. If you have a complaint about the quality of care provide by our facility, The Joint Commission wants to know about it. Submit your complaint by mail or fax. Summarize the issues in one to two pages and include the name and address of the health care organization. Mail: Office of Quality Monitoring, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181 Fax: 630.792.5636. If you have any questions about how to file your complaint, you may contact the Joint Commission at 800.994.6610 between 8:30 am to 5:00 pm CST, Monday through Friday.

6. To file a complaint with Centers for Medicare & Medicaid Services (CMS), 7500 Security Boulevard, Baltimore, MD 21244-1850. Phone: 800.663.4227.

Patient Name (print): _____

Patient Signature: _____

Date: _____ Time: _____

Patient Authorization to Release Healthcare Information

We will retrieve your records and images from your prior imaging center for you. Please complete this form and send to Austin Breast Imaging by scanning and emailing or via fax.

Fax: 512.339.6360
Email: patientaccess@austinbreastimaging.com

Patient's Name: _____ DOB: _____

Previous name (if applicable): _____

I request and authorize _____ *(prior imaging center)* to release my protected healthcare information to:

Austin Breast Imaging
12319 N. MoPac Expressway
Building C, Suite 320
Austin, Texas 78758
Phone: 512.776.1000

This request and authorization applies to the following: (check all that apply)

☐ Mammogram Images and Reports Dates of Service _____
☐ Ultrasound and Images and Reports
☐ Pathology Reports
☐ Bone Density Reports
☐ MRI Images and Reports
☐ Other: _____

The protected health information is being used or disclosed for the following purpose:

☐ Per patient's request for comparison ☐ Other: _____

_____ *Initials* I understand that, as set forth in the provider's policy notice, I have the right to revoke this authorization at any time by sending written notification to the above address or fax number.

_____ *Initials* For screening mammograms, if your comparison mammograms do not arrive in 7 business days then your mammogram will be read at that time without comparison.

Patient Signature _____ Date Signed: _____

Patient History

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Name: _____

Previous Names: _____ Date of Birth: _____ Age: _____ Date: _____

Address: _____

Email: _____ Ethnicity: _____

Home Phone: _____ Work: _____ Cell: _____

Referring Physican _____ Location: _____

Previous breast imaging? ☐ Mammo ☐ Ultrasound ☐ MRI Location: _____ Date: _____

Reason for today's exam: _____ Date of last breast exam by a physician: _____

Do you have any of the following symptoms? If yes, how long?

Lump/Mass ☐ R ☐ L _____ Nipple Inversion ☐ R ☐ L _____

Pain/Soreness ☐ R ☐ L _____ Nipple Discharge ☐ R ☐ L Color: _____

Previous Breast Surgery:

Breast Biopsy ☐ R ☐ L Date: _____

Lumpectomy ☐ R ☐ L Date: _____

Mastectomy ☐ R ☐ L Date: _____

Reconstruction ☐ R ☐ L Date: _____

Reduction ☐ R ☐ L Date: _____

Breast Implants ☐ Yes ☐ No If yes: ☐ Saline ☐ Silicone Date: _____

Implants Removed? ☐ Yes ☐ No Date: _____

Personal History of Breast Cancer: _____ ☐ Yes ☐ No

If yes, date: _____

Radiation? ☐ Yes ☐ No

Chemotherapy? ☐ Yes ☐ No

Hormone Therapy or Tamoxifen? ☐ Yes ☐ No

Reason: _____

Hysterectomy? ☐ Yes ☐ No Date: _____ Ovaries Removed? ☐ Yes ☐ No Date: _____

Taking Hormones? ☐ Yes ☐ No How long? _____ ☐ Estrogen ☐ Progesterone ☐ Other: _____

Last Menstrual Period: _____ Age at 1st Period: _____ 1st Full Term Pregnancy: _____ Menopause _____

Weight: _____ Height: _____ Weight change since last mammogram? ☐ Loss ☐ Gain How many pounds? _____

Do you have a family history of breast cancer? If yes, indicate age of diagnosis. ☐ Maternal ☐ Paternal

☐ Grandmother _____ ☐ Mother _____ ☐ Daughter _____ ☐ Sister _____ ☐ Aunt _____ ☐ Cousin _____

Do you have a family history of Ovarian cancer? If yes, indicate age of diagnosis. ☐ Maternal ☐ Paternal

☐ Grandmother _____ ☐ Mother _____ ☐ Daughter _____ ☐ Sister _____ ☐ Aunt _____ ☐ Cousin _____

Have you been tested for BRCA1 or BRCA2? ☐ Yes ☐ No If yes, results? Yourself _____

☐ Grandmother _____ ☐ Mother _____ ☐ Daughter _____ ☐ Sister _____ ☐ Aunt _____ ☐ Cousin _____

Do you have any family history of male breast cancer? ☐ Yes ☐ No Any Ashkenazi Jewish heritage? ☐ Yes ☐ No

Have you received radiation to the chest between ages 10 to 30 for Hodgkin's disease? ☐ Yes ☐ No

Have you had a breast cancer risk assessment consultation previously? ☐ Yes ☐ No

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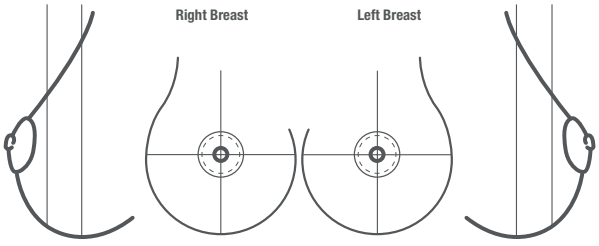

OFFICE STAFF ONLY:

Use the following symbols to mark location of: Lump (V) Scar (#) Mole (0) Tenderness (j)

Is nipple discharge spontaneous? ☐ N/A ☐ Yes ☐ No

Tech Notes: _____

_____

Tech Signature: _____

☐ Baseline ☐ Screening ☐ Diagnostic ☐ Additional Views ☐ Short-Term Flu ☐ PenRad _____

Patient Insurance and Consent

Verify that all information is correct and make changes as needed.

Exam Date: _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____

Social Security #: _____ Patient's Race: _____

E-mail: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Referring Physician: _____ Location: _____

Primary Insured Name: _____ Primary Insured DOB: _____

Relationship to Insured: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____

Primary Insurance Company: _____

Insurance Phone#: _____ ID#: _____ Group#: _____

Secondary Insurance: _____

1.) I understand that it is my responsibility to contact my physician for my results. 2.) I authorize ABI to mail information to me and to identify themselves when leaving a phone message. 3.) I understand that I am responsible for payment of all charges resulting from this visit. 4.) The Radiologist and Pathologist bill separately from ABI. 5.) I have been informed that some insurance carriers will only pay for one screening mammogram every 365 days. 6.) I am aware that any diagnostic studies may be subject to my deductible and/or not covered by my insurance policy. This includes screening mammograms that turn into diagnostic mammograms. 7.) If I elect to have my insurance filed ABI, I give irrevocable authorization that this be done with signature on file. A photo static copy will serve as the original. 8.) I authorize ABI to release or request copies of medical records and x-rays pertinent to the course of my examination. 9.) I certify that I have read and received this information prior to my diagnostic Imaging exam and that I understand it's contents.

I hereby assign any and all right, title, and any interest in any benefits whatsoever of any insurance policy or policies whatsoever to AB for charges of services and expenses rendered and provided by them. I further agree to, and will pay for all charges and expenses not provided for or covered by my insurance. I further authorize ABI Comprehensive Breast Center to release any and all information acquired by them in the course of my treatment.

Patient Signature _____ Date _____

Mammography Disclosure and Consent

You have the right as a patient to be informed about any diagnostic procedure that might involve even though minimal, any risks or complications. This disclosure is not meant to frighten or alarm you, it is simply an effort to make you better informed. X-ray examination of the breast (mammography) is the most accurate method of detecting breast cancer. You should understand, however, that a mammogram is not 100% effective in detecting all breast cancers. Some cancers may be seen on the x-ray study but cannot be felt on physical examination. Other cancers can be felt on physical examination, but cannot be seen on x-ray study. It is estimated that 10% of cancers cannot be detected by the mammogram in certain types of breasts. A negative or normal mammogram does not completely exclude the possibility of breast cancer. Additional views of your breast may be requested by the radiologist. We will call you if this is necessary. It does not mean that your mammogram is abnormal. If you have not had a recent breast examination by a health professional prior to the mammogram, you must contact your doctor for a breast examination. Please remember to perform your monthly Self Breast Examination and notify your doctor of any changes, thickening or lumps that you might encounter. Compression of the breast is necessary to obtain the best possible views of the inside of your breast with the least amount of radiation. This kind of compression, while briefly uncomfortable, is better for you in the long run. It helps us take much clearer x-rays of your breast with much less radiation. It is important for you to realize that compression isn't dangerous and it doesn't damage breast tissue in any way. It also doesn't cause long term discomfort. The presence of an implant poses a special situation for mammographic technique and interpretation since a portion of the breast tissue may be obscured by the implant. In addition, implants are subject to complications such as the possibility of rupture, leakage, or displacement during compression. Even though these complications are not common, you as a patient need to know that they can occur.

Please initial the correct statement: _____ I do NOT have breast implants _____I do have breast implants

Radiation can potentially be harmful to a developing fetus. If there is any possibility that you are pregnant, this exam must be discussed with your physician and possibly rescheduled.

Please initial the correct statement: _____ I could possibly be pregnant _____ I am NOT pregnant

Patient Signature _____ Date _____