TOPS | Comprehensive Breast Center
Physician Owned Entity

Patient ID# [PID]

Name:	Date of Birth:	Age:	Exam Date:

Referring Physician:

Please circle any previous breast Imaging: Mammo / Ultrasound / MRI Date: Location:

Reason for Today's Exam? **When was your last visit with your ordering Physician:**

Do you currently have any of the following symptoms? ☐ YES ☐NO If yes, How long?

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

Pain/Soreness ☐R ☐L **Nipple Discharge** ☐R ☐L **What Color?**

Previous Breast surgery

Breast Biopsy ☐ R ☐ L Date _____

Lumpectomy (for CA) ☐ R ☐ L Date _____

Mastectomy ☐ R ☐ L Date _____

Breast Reconstruction ☐ R ☐ L Date _____

Breast Reduction ☐ R ☐ L Date _____

Personal history of breast cancer

☐YES ☐No Date _____

If yes, did you receive

Radiation Therapy ☐YES ☐NO

Chemotherapy ☐YES ☐NO

Hormone Therapy or Tamoxifen ☐YES ☐NO

Have you had a COVID-19 Vaccine? ☐YES ☐NO If yes, in which arm was it given? ☐ R ☐ L

Breast Implants ☐YES ☐NO If yes, ☐Saline ☐Silicone

Implants Removed / Replaced ☐YES ☐NO Date Reason:

Have you had a Hysterectomy ☐YES ☐NO Date_____ Ovaries Removed ☐YES ☐NO Date _____

Taking Hormones ☐YES ☐NO How long ____ ☐Estrogen ☐Progesterone ☐Other _____

Last menstrual Period: Age at 1st menstruation: Age at 1st full term pregnancy: Age at menopause:

Weight change since last mammogram? ☐Loss ☐Gain How many lbs? Current Weight Height

Is there a family history of Breast Cancer? ☐YES, If yes, age of diagnosis. ☐NO

☐Grandmother ☐Mother ☐Daughter ☐Sister ☐Aunt ☐Cousin ☐Other

Is there a family history of Ovarian Cancer? ☐YES, If yes, age of diagnosis. ☐NO ☐ Yourself

☐Grandmother ☐Mother ☐Daughter ☐Sister ☐Aunt ☐Cousin ☐Other

Tested for BRCA1 or BRCA2? ☐YES ☐NO If yes, results? ☐ Yourself

☐Grandmother ☐Mother ☐Daughter ☐Sister ☐Aunt ☐Cousin ☐Other

Any family history of male breast cancer? ☐ YES ☐NO

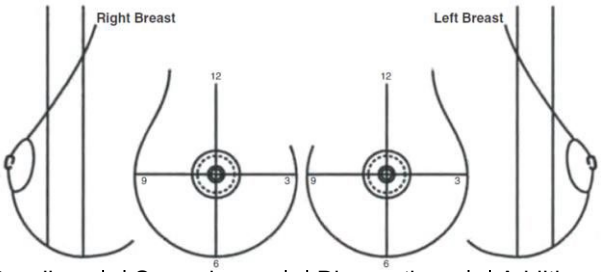
Any Ashkenazi Jewish heritage? ☐YES ☐NO

Have you received radiation to the chest between ages 10-30 for Hodgkin's Disease? ☐YES ☐NO

Have you had a Breast Cancer Risk Assessment Consultation Previously? ☐YES ☐NO

- - - - DO NOT WRITE BELOW THIS - - - - -

Using following Symbols Mark Location of: Lump (V) Scar (#) Mole (0) Tenderness (↑) RA _____%



Is Nipple Discharge Spontaneous? ☐ N/A ☐ YES ☐ NO

Technologist Signature: _____

☐ Baseline ☐ Screening ☐ Diagnostic ☐ Additional Views ☐ Short-Term F/u ☐ Tomo Location _____ PenRad _____

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

Name:	Age:	Sex:	Exam Date:
Date of Birth:	Marital Status:	Patient's Race:	
Address:			
Social Security:	E-mail: [email]		
Home #:	Work #:	Cell #:	
Referring Physician:			
Primary Subscriber Name:	Primary Subscriber DOB:		
Relation to Subscriber:	Primary Subscriber's Employer:		
Primary Insurance Company:			
Insurance Phone#:	ID #:	Group #:	
Secondary Insurance:			

I attest that the above information is correct to the best of my knowledge.

Patient or Authorized Representative Date

Relation to Patient

Witness Date

TOPS Comprehensive Breast Center
Physician Owned Entity

Patient Insurance

TOPS | Comprehensive Breast Center
Physician Owned Entity

FACILITY ACKNOWLEDGEMENT

I understand that TOPS Comprehensive Breast Center is a department of TOPS Surgical Specialty Hospital, a physician owned facility. I also acknowledge that I have the right to choose the provider of my healthcare services and I have chosen TOPS.

Initials _____

AGREEMENT

The undersigned agrees, whether he/she signs as agent or a patient, that in consideration of the services to be rendered to the patient, he/she hereby is responsible for paying facility co-payments, deductibles, estimated facility coinsurance amounts, and any balance deemed not to be a covered benefit of the insurance policy. Monthly statements will be sent to guarantors for patient balances. Acceptable means of payment are cash, money order, cashier's check, credit card, or personal check. Self-pay procedures must be paid in full prior to services.

Initials _____

ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATON TO RELEASE INFORMATION

In consideration of services rendered, I hereby transfer and assign to the hospital and/or physicians indicated all rights, title and interest in any payment due me for services described as provided in the stated policy or policies of insurance.

I have presented my insurance card and photo identification and assign all right to payment due me for medical and/or surgical services under said policies to TOPS Surgical Specialty Hospital, **radiologists, pathological services.** I recognize the above physicians are independent contractors who **will generate separate bills for their respective services.** TOPS Surgical Specialty Hospital provides cost estimates and generates bills for the facility portion only. I understand I am financially responsible for the above physician's service.

TOPS Surgical Specialty Hospital files primary and secondary insurance claims for patients who are not scheduled as self-pay. I authorize the hospital and/or physicians indicated above to release medical information about me as may be necessary for the completion of my insurance claims for this occasion of service to any insurance carrier, health or hospital plan.

Initials _____

INSURANCE

I have been informed that some insurance carriers will only pay for one screening mammogram every 365 calendar days. 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.

Initials _____

MEDICARE PAYMENTS

Patient's Certification, (Authorization to Release Information, and Payment Request) I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Initials _____

PATIENT BILL OF RIGHTS

I understand that I also can receive a copy of the Patient Bill of Rights and Responsibilities.

Initials _____

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CONSENT FOR IMAGING.

I authorize the performance of imaging which the ordering physician and/or radiologist deem necessary in the course of my examination and treatment. I understand that it is my responsibility to contact my physician for results.

Initials _____

POSSIBILITY OF PREGNANCY

Radiation can 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 am NOT pregnant _____. I could possibly be pregnant _____.

Last menstrual period _____

IMPLANTS

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 _____.

RISK ASSESMENT

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

Initials _____

NEEDLE STICK

If an employee or physician has had an accidental needle stick or mucous membrane exposure of my blood or body fluid, I consent to the withdrawal of a blood sample for (included but not limited to) HIV (AIDS), Hepatitis C. I understand the blood test(s) will be done. I understand my test(s) results will be kept confidential to the full extent required by law. If this test is required due to accidental needle stick – not pre-surgical testing - there will be no further cost to me for this –these blood test(s).

Initials _____

PATIENT SIGNATURE ***DATE OF BIRTH*** ***TODAY'S DATE***

WITNESS ***TODAY'S DATE***

Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Home # _____

Work # _____

Mobile # _____

Other _____

E-Mail Communication Preferences

Email Address _____

Patient Name: _____

Date of Birth: _____

Exam Date: _____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that TOPS Surgical Specialty Hospital and TOPS Comprehensive Breast Center, its legal agents, or affiliates may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device.
If an email address has been provided, TOPS Surgical Specialty Hospital and TOPS Comprehensive Breast Center, its legal agents, or affiliates may contact me with an email notification regarding my care, our services, or my financial obligation.

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you receive may contain your personal information. If you would like us to contact you by text message please sign this consent below. If you consent to receiving text messages you also agree to promptly update TOPS Surgical Specialty Hospital and TOPS Comprehensive Breast Center when your mobile phone number changes. You are not required to authorize the use of text messaging and a decision not to sign this portion of the authorization will not affect your health care in any way.

_____

Patient's Signature for consent to text message.

Mail Communication Preferences

May we send mail to your home address? (**If no, please provide an alternate mailing address below**.)

_____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

	Name:	**Telephone**
☐ Spouse	_____	_____
☐ Caretaker	_____	_____
☐ Child	_____	_____
☐ Parent	_____	_____
☐ Other	_____	_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____

Patient or Personal Representative Signature **Date**

_____ _____

Printed Name **Relationship to Patient**

TOPS SURGICAL
SPECIALTY HOSPITAL

PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have received a copy of the Privacy Notice (H I PAA) for TOPS Surgical Specialty Hospital. Privacy Notice Revision Date: June 1, 2017.

_____ _____

PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE DATE

_____

PERSONAL REPRESENTATIVE'S RELATION TO PATIENT

SHADED AREA FOR USE BY TOPS Surgical Specialty Hospital Personnel Only.

DOCUMENTATION OF GOOD FAITH EFFORT

The patient identified above was provided with a copy of the TOPS Surgical Specialty Hospital's Privacy Notice (HIPAA) on this date. A good faith effort has been made to obtain a written acknowledgment of the patient's receipt of the Privacy Notice (HIPAA). However, acknowledgment has not been obtained because:

- ☐ Patient refused to sign the Privacy Notice Acknowledgment.
- ☐ Patient was unable to sign because:

_____

- ☐ There was a medical emergency. TOPS Surgical Specialty Hospital will attempt to obtain acknowledgment as soon as practical.
- ☐ Other reason, described below:

_____

_____

_____ _____

EMPLOYEE SIGNATURE DATE