NEW PATIENT - INFORMATION FORM

Last Name: _____ First Name: _____MI:_____

Date of Birth: _____/_____/_____Social Security #: _____-_____-_____

Address: _____

City:_____State:_____ZIP_____

Phone Number: Cell:_____ Home/ Work: _____

Does WIS have your permission to leave messages at the numbers listed above? YES or NO

Email Address:_____

Physician(s) you wish to receive your results (ie. Primary Care/OBGYN) :_____

_____

IMPORTANT

I, the patient or parent of minor child, attest that the information completed above is accurate. I understand that this information will be kept on file and will be used for billing purposes.

By signing this authorization; I understand that the FDA recommends annual screening mammograms after the age of 40. I understand that my insurance may not cover this exam if I have not yet reached the recommended age of 40 or I have not met my plan requirements. Many insurance carriers allow only one screening mammogram every 12 months. I understand and acknowledge it is my responsibility to understand my insurance benefits pertaining to screening mammograms, diagnostic mammograms, breast ultrasounds and bone density or DEXA scans. I understand if it has been less than 1 year and 1 day since my last mammogram, I may be responsible for today's charges.

I hereby authorize the release of my medical and/or other information required for processing my insurance claim from my insurance carrier to WIS. I, Guarantor, hereby acknowledge and accept responsibility for payment in full for all services rendered to me by Women's Imaging Specialists.

MAMMOGRAM INFORMED CONSENT (Electronic Informed Consent for Screening Patients)

1. I understand that a mammogram is only 90% accurate in detecting breast cancer and is only a partial examination for diagnosing breast cancers.
2. I understand, based on my clinical symptoms, I may be referred for additional mammogram images, for an ultrasound, or to a surgeon.
3. I understand that I am responsible for getting my results if I have not heard from my physician after two (2) weeks.
4. I understand that if, after seeing my physician, I continue to have breast problems (regardless of a negative report on the mammogram), I will contact my physician for instructions on further follow up.

_____ _____/_____/_____

Signature of Patient or Guardian **Date**

INSURANCE ASSIGNMENT AND FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

INSURED PATIENTS

I, the undersigned, certify that I (or my dependent) have active insurance coverage with _____ _____ and assign directly to Women's Imaging Specialists all insurance benefits, if any, otherwise payable to me for services rendered.

I hereby authorize the facility to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

I further understand:

All co-payments, deductibles and non-covered services must be paid upon receipt of your first statement. If I am unable to pay this amount in full, or I require special payment arrangements, I must request this in writing or by phone upon receipt of my first statement.*

WIS can provide an estimate of the fee's for my services today. However, I understand this amount is an estimate and all final amounts will be determined after my insurance company has processed and paid or denied my claim.*

Women's Imaging Specialists will submit claims to my insurance company as a service to me. It is my responsibility to understand my insurance benefits and coverage. I understand services not covered by my insurance are my responsibility.*

If my insurance company requires a referral or preauthorization from my referring physician, it is my responsibility to request and obtain this and submit to my insurer. Women's Imaging Specialists is not responsible to obtain this authorization; and, I understand that failure to obtain necessary authorizations may lead to a denial of benefits and additional financial responsibility on my part.

REQUEST FOR WAIVER OF COPAYS, COINSURANCE AND/OR DEDUCTIBLES: Women's Imaging Specialists participates in most commercial insurance plans, and as such charges submitted under these participating plans will be processed at the in-network benefit level. While most insurance plans consider breast imaging services as eligible, there may be times when certain plans require copayment, coinsurance, and/or deductibles. In the event that my exam results in a balance due which will cause financial hardship, you may request for these charges to be waived. **Upon request, Women's Imaging Specialists will provide you with the appropriate forms to make such a request**.

Additionally, I understand that regardless of how my insurance company pays or denies my 3D tomosynthesis mammogram , $50.00 is the maximum amount for which I am responsible.

UNINSURED OR SELF-PAY PATIENTS

I, the undersigned, understand and acknowledge that I am financially responsible for all charges resulting from services rendered at Women's Imaging Specialists for all dates of service for which I am uninsured.

I understand that payment is due at the time of service and that a schedule of fees for services is available at the reception desk. Women's Imaging Specialists accepts cash, checks and credit/debit cards.

I further understand that if I am unable to pay for services in full, I may be eligible for a payment plan if I agree to all of the terms and conditions contained in the payment agreement including, but not limited to, authorizing automatic monthly payments.

I understand failure to pay according the terms of my payment arrangement will result in my account being referred to a collection agency and my delinquency reported to the three major credit companies.

I have read the above Acknowledgements and Agreements and fully understand the same.

_____ _____/_____/_____

Signature of Patient or Guardian **Date**

ACKNOWLEDGEMENT - NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.
I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions.

Patient Name: _____**Date of Birth:** _____/_____/_____

Signature:_____ **Date:** _____/_____/_____

OFFICE USE ONLY – PATIENT REFUSAL

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so as documented below.

Reason:_____

Employee Name:_____Date____/_____/____

Women's imaging specialists

AUTHORIZATION FOR RELEASE
MAMMOGRAM IMAGES & BREAST HEALTH INFORMATION

Patient Name:_____ **Date of Birth:** ____/_____/_____

Patient Social Security Number:_____-_____-_____

Date of PRIOR EXAM: _____/_____/_____ **or No Previous Exams – Patient Initials**_____

Please check or list the location below of where your prior mammogram was performed:

Thomas Medical Center	Woman's Group
South Baldwin Medical Center	Springhill Medical Center
Ann L. Baroco Center for Breast Health	USA Health Woman's Imaging
Baptist Hospital	NAS Pensacola Hospital
West Florida Hospital	Precision Imaging
Angel Williamson Imaging Center	
Woodlands	
Name of Facility with City & State	

I hereby authorize the practitioner and/or the facility listed above to release my mammogram films/discs, mammogram and/or pathology reports, and any other information pertaining to my breast history to Women's Imaging Specialists:

Please forward **all <u>FILMS and DISCS</u> to:**

1229 Gulf Shores Pkwy., Suite 100
Gulf Shores, AL 36542

Phone 251-255-6262
Fax 251-256-0901

Patient Signature: _____ **Date:** _____/_____/_____

For Office Use Only

Request By: _____ **Date:** _____/_____/_____

Fax Number: _____