Tampa Bay Breast Care Specialists, LLC
3000 Medical Park Drive, Suite 140
Tampa, FL 33613
Phone: (813) 978-8315 Fax: (813) 910-0160 http://www.tampabreastcare.com

Pre-Appointment Instructions

What to bring:

Bring your latest mammograms and ultrasounds, if applicable, along with the xray films. Patients will need to call the facility where you had your mammograms and/or ultrasounds and request them to be ready for pick up. Most facilities require at least a 48 hour advance notice.

What to expect:

For those patients with palpable breast lumps, a minor biopsy may be offered at the initial visit. This is done under a local anesthetic. Patients do not need to have a driver, but we encourage patients to bring a loved one or a friend for support.

For those patients being referred for an abnormal mammogram showing calcifications or other non-palpable abnormalities, Dr. Cox will review the necessary surgical options if these calcifications or abnormalities in deed need further evaluation. He must have the outside films and reports to make a complete evaluation.

For those patient's being referred for a new diagnosis of breast cancer, we will work together to help our patients organize the road to recovery. Surgical intervention is the initial step to the fight against breast cancer. Our patients may require radiation therapy and/or chemotherapy.

We will refer our patients on to a radiation oncologist as well as a medical oncologist once we have all the necessary tools for their consultations and evaluations.

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PATIENT QUESTIONNAIRE

Patient's Name		Date:	
Age:		Date of Birth:	
Referring Physician:			

MEDICATION ALLERGIES (explain any reactions)

Allergen	Reaction

MEDICATIONS (list all medicines and dosages if known)

If you are taking hormone replacement drugs, please note how long you have been on them.

Are you taking any anti-coagulants (i.e. asprin, acetominophen, ibuprofen)? ☐ No ☐ Yes If yes, please list below.		
Medicine	Dose	How long?

PAST MEDICAL HISTORY

Have you ever had a heart attack?	☐	No	☐	Yes	Year	
Do you have a pace maker or stent?	☐	No	☐	Yes	Which	
Do you have asthma, emphysema, chronic bronchitis or chronic lung disease? ☐ No ☐ Yes (please circle which ones)						
Do you have diabetes or high blood sugar?	☐	No	☐	Yes		
Any other medical problems?	☐	No	☐	Yes		
If yes, please explain:						

PREVENTIVE MEDICINE

When was your last mammogram?	Date	/ /

Do you have a PERSONAL HISTORY OF CANCER?	☐	No	☐	Yes

If yes, then please fill in the following information. If you had breast cancer, please indicate which breast.

Cancer Type:								
Date of Diagnosis: (month and year is sufficient)								
Treatment Received/Surgery./Date:								
Status of disease now:	☐	Cured	☐	Remission	☐	Relapse	☐	Other:

(If you have any additional personal cancer information, please write it on back of the page)

PAST SURGICAL HISTORY (i.e. any operations and approximate dates)

PLEASE include any breast biopsies or breat augmentations, and which breast.

Operation	Month/year

FAMILY HISTORY OF CANCER

Has any family member been diagnosed with cancer? (such as, leukemia, ovarian, colon breast, pancreatic, melanoma, etc.)	☐	No	☐	Yes

If yes, please list family member(s) and cancer below, whether the person was on your mother's or father's side, and approximate age when the cancer was found. Write on the back if you need more space.

Family Member	Type of Cancer	Age of Patient at diagnosis	Current status of patient

SOCIAL HISTORY

Marital Status:	☐ Single	☐ Married	☐ Widowed ☐ Divorced
Employment Status:	☐ Full-Time	☐ Part-Time	☐ Retired
Place of Birth:			
Religion (optional):			
Race:	☐ Caucasian	☐ African-American	☐ Hispanic
☐ Asian, (ie. Chinese, Indian, Japanese)	☐ American Indian, Aleut Eskimo		☐ Other:
Main Language:	☐ English	☐ Spanish	☐ Other:
Have you ever smoked cigarettes?			☐ No ☐ Yes
If yes, how long?		Packs per day:	Quit year:
Are you still smoking?			☐ No ☐ Yes
Do you drink alcoholic beverages?			☐ No ☐ Yes
If yes, what type? ☐ Wine ☐ Beer ☐ Hard liquor For how long?			
If yes, check what applies ☐ Rarely ☐ Socially ☐ Daily ☐ Weekly			
☐ 1-2 per day	☐ 3-4 per day	☐ 5 or more per day	☐ Other:

Please use this space for any additional information you would like to communicate to the physician....

If you would like any other physician to receive your visit note from our facility, please fill out their information below:

Name of Practice: ____

Name of Physician: ____

Address: ____

____

____

Phone Number: ____________________________ Fax Number:_____________________________

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SPECIAL ASSIGNMENTS/AUTHORIZATION
(Please Read Carefully)

CONSENT TO TREATMENT

I hereby consent to and authorize the performance of all appropriate procedures and courses of treatment, the administration of all local anesthetic and/or blocks, and any and all medication and technical procedures, which in judgment of the health care provider attending and consulting may be considered necessary or advisable to treat:

Me_______________________________________ - OR – My__________________________/________________________________
(Print Name) (Relationship) (Print Name)

While a patient of a physician in the employment of Tampa Bay Breast Care Specialists.

In addition to the above:

- I consent to the appropriate disposal by Tampa Bay Breast Care Specialists of any specimens or other bodily materials removed during technical procedures or for testing purposes.
- I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantee has been made as to the results of any therapies and/or procedure(s).

PATIENT VALUABLES
Tampa Bay Breast Care Specialists does not accept responsibility for any personal property (monetary or sentimental).

ASSIGNMENT OF INSURANCE BENEFITS
I hereby certify that the following information given by me in applying for payment under the Titles XVIII and XIX of the Social Security Act or by any third-party payers is correct. I assign payment to Tampa Bay Breast Care Specialists of all benefits due me under the terms of said policies and programs. I assign payment to the Physician(s)/Healthcare Provider rendering medical services, the in hospital based Specialist, and the Physician(s)/Healthcare Provider for whom the hospital is authorized to bill in connection with its services. I understand that I am required to pay for any health insurance deductibles; coinsurance or any other charges incurred which are not paid by my insurance or other third-party payers together with all costs of collection, if necessary, including a reasonable attorney's fee if collected by or through an attorney at law.

RELEASE OF INFORMATION
I do hereby authorize Tampa Bay Breast Care Specialists and any physician/health care provider examining and/or treating me to release any medical information and records concerning diagnosis and treatment either during inpatient or outpatient treatment for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

FINANCIAL AGREEMENT
In consideration of medical treatment and services given to the patient, the undersigned unconditionally guarantees payment in full to Tampa Bay Breast Care Specialists (TBBCS) for all services rendered. Any uninsured portion of patient's account will remain payable when services are rendered. Any effort by TBBCS to collect insurance proceeds does not affect the responsibility of the patient and/or the undersigned guarantor, except to the extent TBBCS receives insurance proceeds. If TBBCS does not receive insurance proceeds within 60 days from billing, TBBCS will notify the patient and/or the guarantor who will be required to pay the balance in full. Should TBBCS find it necessary to refer this account to an attorney for collection to enforce the obligations of the patient and/or the undersigned the patient and/or the undersigned agrees to pay all collections expenses, including a reasonable attorney's fee. If a legal action is taken in connection with this agreement, the proper venue for such action shall be in Hillsborough County, Florida. All co-payments are required at time of service and appointment will be rescheduled if not paid.

HMO ELIGIBILITY GUARANTEE
I hereby certify that I am enrolled in an HMO and/or MediPass that I am receiving health care services authorized through the primary care physician that I have chosen or has been assigned to me or through my HMO plan. I understand that if the above is not true or if I am not eligible under the terms of my medical and hospital subscriber health insurance agreement, I am liable for all charges for the services rendered. Also, if the above is not true, I agree to pay in full for all services received within thirty (30) days of receiving a bill from Tampa Bay Breast Care Specialists. All HMO referral authorizations are the responsibility of the patient, and if proof of authorization has not been obtained and service has been rendered, patient accepts full responsibility of payment to TBBCS.

My signature represents that I have read the above and thereby give me agreement and authorization to all of the above:

____ ______________________________
(Signature) (Date)

____
(Print Name)

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Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

- At Tampa Bay Breast Care Specialists' practice, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If we change any of the details of this notice, we will notify you of the changes in writing.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint; however, before filing a complaint, we recommend you seek more information regarding your health information privacy by contacting our Privacy Officer at 813-978-8315.

This notice is in effect as of April 14, 2003.

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Acknowledgement of Receipt for Notice of Privacy Practices

By signing this document, I acknowledge that I have received a copy of ________________________'s Notice of Privacy Practices.

_______________________________ _____________________________ ______________
Name (Please print) Signature Date

If signing as a parent or guardian, please not the name of the patient __________________________

FOR INTERNAL OFFICE USE ONLY

Date Acknowledgement Received _____________________
or
Reason Acknowledgement was not obtained:

_______________________________ _____________________________ ______________
Name (Please print) Signature Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:____ DOB:__________________________

Phone Number:____ SS#:___________________________

Contact Person(if other than patient):____________________________________Phone:_________________________

I authorize Tampa Bay Breast Care Specialists to release my medical records (including medical information related to the diagnosis or treatment of HIV testing, drug and alcohol, or a psychiatric condition) as specified below:

Visit Type

❑ Emergency Visits: Service Date(s):________________________________
❑ Inpatient Hospitalization: Admission/Discharge Dates:______________________
❑ Outpatient Service: Service Date(s):________________________________
❑ All of the Above: Inclusive of all dates.

Medical Information

❑Complete Medical Record
❑ Demographic/Visit Hx
❑ Operative Reports
❑ EKG & Radiology Reports
❑ Xray
❑Lab
❑ Discharge Reports
❑ Consultation Reports
❑Pathology Reports
❑ Hx & Physical Exam
❑Other:____

REASON FOR REQUEST:____

Delivery Mode

❑ Patient/Designee to Hand-Carry. Please notify patient/contact at above number when records are available for pick-up.
May we leave a message to notify you that records are ready? ❑Yes ❑ No
Medical Records Picked Up On: ________________________ Please Initial:_______

❑ Mail copies to the following individual/organizations:
Name: ____
Street Address: ____
City, State and Zip Code: ____

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Services department. I understand revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise specified, this authorization will automatically expire in one year.

Copies to the patient will be at no charge the first time. Additional copies to the patient will be assessed a charge. There will be a charge for copies being sent to attorneys, insurance agencies or other companies other than a medical facility for treatment.

Signature: ____ Date: ____________________