

Tennessee Breast Specialists

Laura Dunbar, M.D.

Ben Furman, M.D.

Laura Lawson, M.D.

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

Social Security#: _____ Employer: _____ Work Phone: _____

Work Address: _____
(STREET) (CITY) (STATE) (ZIP)

Referring Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____
 Address: _____ Relationship: _____
(STREET) (STATE) (ZIP)

Responsible Party Name: _____ Relationship: _____

Address: _____ Phone: _____

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: _____
(PATIENT OR AUTHORIZED PERSON)

Tennessee Breast Specialists
RELEASE OF INFORMATION

Laura Dunbar, M.D.

Ben Furman, M.D.

Laura Lawson, M.D.

Name: _____ **Today's Date:** _____

I, _____, hereby authorize the Tennessee Breast Specialists (TBS) 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 TBS 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 TBS 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 Tennessee Breast Specialists. Please contact the Privacy Officer or Privacy Contact in writing to terminate this authorization at:

Tennessee Breast Specialists
300 20th Ave. North, Suite 106
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 Tennessee Breast Specialists will not be jeopardized whether I provide the requested authorization.

Signature of Patient or Person Representative Date

Printed name of Patient, or Personal Representative Patient's Date of Birth

Witness Date

Name _____ Today's Date _____

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? ____ 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 state "yes" if present and circle if given choices.)

Constitutional: Weight loss or gain _____ (if so, how much) _____ Cold or flu _____ Fatigue/Lethargy _____

Neurological: Blindness _____ Fainting _____ Weakness on one side _____ Seizures _____

Respiratory: Smothering _____ Shortness of breath _____ Persistent cough _____ Difficulty Breathing Deeply _____

Cardiovascular: Shortness of breath lying flat _____ Chest pain like a heart attack _____ Swelling (where?) _____

Gastrointestinal: Indigestion _____ Vomiting _____ Diarrhea _____ Blood in stool _____ Constipation _____

Urinary: Trouble passing urine _____ Frequency _____ Urgency _____ Pain _____

Musculoskeletal: Shoulder, Back, Neck or Chest Pain _____ Arthritis _____ Muscular or Joint Pain/Tightness _____

Stiffness _____ Limited Range of Motion _____ Weakness _____ Difficulty in Daily Tasks (dressing, etc.) _____

Skin Trouble: Y, N Explain: _____ Lymphatic: Swelling in glands: _____

Psychiatric: Depression _____ Anxiety _____ Suicidal thoughts _____

Endocrine: Excessive thirst or urination _____ Feeling too hot or cold _____

Breast Health Information: Please list any previous breast problems or breast surgery:

Tennessee Breast Specialist
Please update at each visit.

Patient History Update

Name _____ Today's Date _____

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? _____ Approximate dates: _____

Have you ever taken hormones? _____ What kind? _____ Dose? _____ How long? _____

Have you ever had a Breast Biopsy? _____ If yes, when? _____ Outcome? _____

Have you had your Uterus removed? _____ If yes, when? _____ Outcome? _____

Have you had your Ovaries removed? _____ If yes, when? _____ Outcome? _____

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

Tennessee Breast Specialists

Family History Questionnaire
For Breast and Ovarian Cancer

Patient Name: _____

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			
Aunt's			
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	Ovarian Cancer at Any Age

PHARMACY INFORMATION

For future prescriptions, please fill out the following.

Patient name: _____

Pharmacy Name: _____

Pharmacy location: _____

Pharmacy Phone : __ (____) _____ - _____

Financial Policy

Co-Pays: I understand that co-pays are due in full-at the time of my visit.
Tennessee 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

Patient Signature

Date

Tennessee Breast SpecialistsHIPAA NOTICE OF PRIVACY
PRACTICES

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

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.

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 Tennessee 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

Signature Page - Office Copy

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Uses and Disclosures of Protected Health Information

Treatment

Payment

Healthcare Operation

Other Permitted and Required Uses and Disclosures

You may revoke this authorization

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

Print Name: _____

Signature: _____ Date: _____