breastlink
The Breast Care & Imaging Center

** To be completed using black ink**

Breastlink
Patient Registration

Patient Information:

First Name: _____ Last Name: _____ Date of Birth: _____

Address: _____ City: _____State: _____ Zip: _____

Home Ph: ( ) _____ Cell Ph: ( ) _____ Wk Ph: ( ) _____

Driver's License #: _____ Social Security #: _____ Email address: _____

Gender: ____Female ____ Male Marital Status (circle one): Single Married Divorced Widowed

Employer/School: _____Occupation: _____If student, Full Time: _____ Part Time:_____

Employer/School Address: _____

Name of Referring Provider: _____Phone Number: _____

Address of Referring Provider: _____City: _____State: _____ Zip: _____

PCP Name (if different from above): _____ Office Ph: ( ) _____

PCP Office Address: _____City: _____ State: _____ Zip:_____

Emergency Contact: _____ Relationship: _____ Phone: ( ) _____

How did you hear about us? [ ] Website [ ] Friend [ ] Family member [ ] Referring MD: Name: _____ [ ] Other _____

Insurance Guarantor Information:

Name of Insurance Subscriber: _____ Date of Birth: _____Relation to Patient: _____

Phone Number: ( )_____ Driver's License #: _____ Social Security #: _____

Primary Insurance Information:

Insurance Company: _____ Phone Number: _____ Policy #: _____

Group Number: _____ Effective Date: _____ Specialist Co-pay amount (if applicable): $ _____

Insurance billing address: _____City: _____ State: _____ Zip: _____

Secondary Insurance Information:

Insurance Company: _____ Phone Number: _____ Policy #: _____

Group Number: _____ Effective Date: _____Specialist Co-pay amount (if applicable): $_____

Insurance billing address: _____City: _____ State: _____ Zip: _____

Authorization for Assignment of Benefits: By my signature below, I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due me under my insurance plan. I agree to pay the balance of charges not paid under my plan. I also hereby authorize this provider to use and disclose any of my personal medical information for treatment and payment (including to my insurance company). Should the account be referred to an attorney for collection, the undersigned shall pay attorney's fees and other collection expenses. IF I AM UNINSURED, that I am fully responsible for all charges/services provided at my appointment and payment is due at the time of service.

Authorization and Consent for Medical Care/Treatment: By my signature below, I hereby authorize Breastlink to furnish the necessary medical treatment or procedures including but not limited to laboratory procedures, chemotherapy agent or such drugs, surgical procedures, and supplies as ordered by the attending physicians), his assistants, or designees. I further recognize that the physicians who practice at Breastlink may not be employees or agents of Breastlink but independent physicians. Breastlink contracts with these physicians for services normally provided and questions relating to care that my physician has given or ordered should be addressed to him/her.

Lifetime Medicare B Signature Authorization: By my signature below, I authorize my holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare & Medicaid Services or it's intermediaries or carriers, or to the billing agent of Breastlink and information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits be made to the holder of this assignment on my behalf. I understand that I am responsible for the deductible and co-insurance.

Patient Signature: _____ Date: _____

breastlink
The Breast Care & Imaging Center

Breastlink Confidential Channel Communication Request

As required by the Health Information Portability and Accountability Act (HIPAA) of 1996, you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some methods of contact must be provided, and as appropriate, information as to how communication will be handled.

I, _____ (print name) Date of Birth: _____, hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or any matters relating to the care I am receiving at Breastlink Medical Group. This request supersedes any prior requests for confidential channel communications I may have made.

Please select all that apply. Where you list more than one (1) communication option, please indicate which you prefer.

□ **Phone**

I want you to contact me by telephone at: ( ) _____ and/or ( ) _____

□ **DO** □ **DO NOT** leave messages on my answering machine.

□ **DO** □ **DO NOT** leave messages with any other person.

Please indicate name, if any, of the individual(s) approved to take the above messages:

_____

□ **Diagnosis & Treatment**

I □ **DO** □ **DO NOT** want you to discuss my diagnosis, treatment, or any health related matters with my family members or anyone on my behalf.

If you authorize to speak to members of your family or anyone on your behalf regarding your diagnosis, treatments, or any health related matters, please provide the names of those authorized individuals:

□ **Mail**

I want you to contact me at the following mailing address:_____

City: _____State: _____ Zip: _____

Signature: _____Date: _____

Print Name: _____

If not signed by patient, please indicate relationship:

□ Parent or guardian of minor patient

□ Guardian or conservator of an incompetent patient

□ Beneficiary or personal representative of deceased patient

****

Office Use Only: □ Alteer Alert Screen updated on _____ (insert date) by: _____ (employee Name)

breastlink
The Breast Care & Imaging Center

Breastlink Physician-Patient Arbitration Agreement

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated:** It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort contract, or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses, and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees, and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provisions(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____
Physician's or Duly Authorized Representative Signature (Date)

By: _____
Patient's Signature (Date)

By: _____**Breastlink Medical Group, Inc.**_____
Print or Stamp Name of Physician, Medical Group or Association Name

_____
Print Patient's Name/ Date of Birth

By: _____
Signature of Translator (if applicable) (Date)

By: _____
Patient's Representative's Signature (if applicable) (Date)

_____
Print Name of Translator

_____
Print Name and Relationship to Patient

breastlink
The Breast Care & Imaging Center

Authorization of Release of Breastlink Medical Records

I, _____ hereby authorize, Breastlink Medical Group, to release medical records and information pertaining to chart documents:

Patient's Name: _____ Date of Birth: _____

Specific date of Service: _____ Entire Chart: Yes [ ] No [ ]

And/or specific records:

_____

If records are not to be picked up at the Breastlink office, records are to be sent to:
Name: _____ Phone #: ( )_____

Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize disclosure of the health information for the above named patient. I understand that this authorization shall become effective immediately and shall remain in effect until three months from date of signature, or until I revoke it, in writing, whichever occurs first. Additionally I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law. I understand and accept the statements contained in this authorization.

Print Name: _____

Signature: _____ Date: _____ Time: _____ am/pm

If signed by other than patient, please indicate relationship: _____

Witness Name: _____ Signature: _____

FACSIMILE NOTICE:
This notice is intended only for the use of the individual or entity named above and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication by error, please notify us immediately.

breastlink
The Breast Care & Imaging Center

Breastlink
Financial Policy

Breastlink is committed to providing you with top quality care. As a part of your care, we believe it is important for you to be educated about our financial policy as outlined below:

Insurance coverage:
If you are a new patient, please provide us with your insurance card for both your primary and secondary insurance carriers as well as a copy of your pharmacy insurance card (if applicable) at the time of your appointment. If you are an existing patient, and you have any changes to your insurance, please provide updated copies at your next scheduled appointment or contact our billing office with your updated information. You will be asked annually for a new copy of your card. If you change insurances, please inform us of the change and provide us with a copy of your new card before your next visit. In addition to the billing information on your card, it is necessary to have access to the most current information regarding pre-certification and authorizations for any services needed within our practice. You as the patient are responsible for any and all deductibles, co-insurance, and any non-covered services as deemed by your health insurance plan. Due to the complexity of care being provided within our practice, some treatments and procedures may not be considered medically necessary by your insurance carrier as a covered benefit even though we have found them to be clinically indicated.

Secondary insurance- as a courtesy to our patients, the secondary policy will be billed for any remaining balances after payment processing and claim review of the primary insurance. Due to the allowed claim processing time for your primary insurance carrier, please allow up to 60 days after your date of service for secondary insurance processing to occur.

Co-payments: Any and all co-payments are due at the time of service. A co-pay is a portion of a fee paid for all lab/ injection visits, chemotherapy infusion visits, and office visits with a Physician, a Nurse Practitioner, and/or Physician Assistant. Co-payments are a contractual fee with the health plans required to be paid by you as the patient. Co-payments and deductible fees cannot be waived or discounted.

Patients with no insurance benefits:
If you do not have insurance coverage, we offer a 20% discount to “cash only patients” at the time of service when payment is by cash, check, or credit card (Visa, MasterCard, and Discover). Failure to pay at the time of service will result in no discount and you will be held financially responsible for the entire cost of the service(s) provided.

Medicare:
Breastlink, as a Medicare provider, agrees to accept the allowed payments as determined by Medicare. The patient is responsible for any and all deductibles, co-insurance, and any non-covered services. If you have secondary insurance, your secondary insurance will be billed. Due to the complexity of care being provided within our practice, some treatments and procedures may not be considered as a covered benefit even though they are clinically indicated.

Returned Check Policy:
If a check is returned to us with for non-payment or insufficient funds, we will assess a $25.00 fee to your Breastlink account and you will be billed accordingly.

All Patients:
My signature below represents my acknowledgement of the financial policy as outlined above. I further understand that I will be held financially responsible for any and all charges denied by my health plan and/or if I present with no insurance benefits.

Name (please print): _____ Date of Birth: _____

Signed: _____ Date: _____

breastlink
The Breast Care & Imaging Center

Breastlink Outside Physician Information Sheet

Patient's Name: _____ Date of Birth: _____

Patient's Signature: _____Date: _____

Please indicate below all of the physicians who you would like to receive information by mail regarding any exams and/or consultations which you have had at our facility. Please indicate whether the physician is your primary care physician, OB/GYN, surgeon, or another specialist. In order to assist in sending your other physicians updated copies of your records, please provide as much information as possible.

Physician's Name: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: ( ) _____ Fax #: ( ) _____

Physician's Name: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: ( ) _____ Fax #: ( ) _____

Physician's Name: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: ( ) _____ Fax #: ( ) _____

Physician's Name: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: ( ) _____ Fax #: ( ) _____

breastlink
The Breast Care & Imaging Center

Race and Ethnicity Questionnaire

At Breastlink we believe that the best medical practice is informed by state of the art clinical research. Because of this, we develop our own clinical trials in addition to collaborating with industry sponsors and NCI-funded cooperative groups. Through these clinical trials we pursue investigational drug therapies as well as interventions to improve the quality of life concerns of our patients. Our trials address a large collection of concerns including: energy recovery-diet and nutrition, fertility, sexuality and cognitive recovery.

To ensure that everyone has access to clinical research and interventions that are relevant to their medical concerns, Breastlink must provide research sponsors with information about the patients we serve. This information includes: identification of what patient needs are, and demographic information which includes race and ethnicity. All of this information allows Breastlink and researchers to make sure each patient has access to the trials that address their specific medical concerns.

Additionally, our growing knowledge of molecular or tissue profiling has helped doctors understand differences in breast cancers that are specific to the racial and ethnic heritage of our patients. This knowledge will increasingly inform how we determine the appropriate treatment in the event that a patient faces a breast cancer diagnosis or recurrence.

We hope that you will assist us in our ability to provide the very best interventions that will serve the broadest possible population, by providing us with this data. However, supplying your information is voluntary and you will not be disadvantaged in your care in any way if you should decide not to assist with this effort.

Thank you!

The information collected will be kept confidential and will only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those that require the information for federal reporting purposes.

Name (Please Print): _____ Date of Birth: _____

Racial Classification: (Please check all that apply)

( ) White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

( ) Black or African American: A person having origins in any of the black racial groups of Africa.

( ) Native Hawaiian or Other Pacific Islander: A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

( ) Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including (for example) Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

( ) American Indian or Alaska Native: A person having origins in any of the original peoples of North America and South America (including Central America), and who maintain tribal affiliation or community attachment.

Ethnic Classification: (Please check one group only)

( ) Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

( ) Non- Hispanic

( ) Unknown

breastlink
The Breast Care & Imaging Center

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to out use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, to determine research eligibility, review of clinical data associated with participation in a research trial, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by:_____
Printed Name of Patient or Representative

Signature:_____ Signature Date:_____

Relationship to the Patient
(If other than the Patient):_____

Witness: _____ Signature Date:_____
Printed Name of Practice Representative