MID-ATLANTIC IMAGING CENTERS

Mammography
Breast Ultrasound
Bone Densitometry

BREAST ULTRASOUND QUESTIONNAIRE

Name____Date__________________

Physician______________________________ Daytime Phone #:______________________________

SS#:__________________________ Birth Date ______________________ Age_____________

For MAWC-IC Use : Acct#_____________ X-Ray# _____________

Is there a possibility that you could be pregnant? ____________ Date of LMP ____________________

Have you ever had a mammogram? _________ Where? ____________________ Date? __________

Have you ever had a breast ultrasound? ______ Where? ____________________ Date? __________

Have you ever had a breast biopsy or aspiration of a breast cyst? ______________________________

Reason for this breast exam: (please check applicable box/s)

________Lump (something that one can feel with their fingers)

________Abnormal mammogram

________Nipple discharge

________Other reason – please explain:____

If a breast lump is the reason for this exam please answer the following questions:

Who first noted this lump? (Please circle) You Your Physician Other (who?)______________

How long have you been aware of this lump? _______________Is the lump tender? ____________

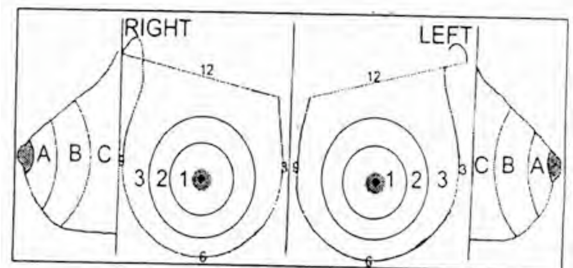
Do you recall any injury to your breast? (Please describe) ___________________________________

____

Does the character of this lump change with your menstrual cycle?____________________________

TECHNOLOGIST'S COMMENTS

ABC – depth of lesion
1,2,3 - distance from nipple



Technologist: ______________________________

MID-ATLANTIC IMAGING CENTERS SCHEDULING PROTOCOLS FOR MAMMOGRAMS – BONE DENSITY – BREAST ULTRASOUND

Thank you for choosing Mid-Atlantic Imaging Centers to have this important healthcare exam(s) performed. Our friendly and experienced staff is ready to give you personal, professional service using the latest digital equipment. Please read the instructions carefully that are provided below. Failure to comply may result in MAIC not being able to perform your exam at your scheduled date or time.

SCREENING MAMMOGRAM: Annual exam; you or your doctor has found NO problems with either breast. *If you find a problem before you come in for your screening mammogram you **must** see your doctor for a script as the mammogram will change to a diagnostic exam.

A. Been seen at MAIC before: you must bring current insurance card, picture ID, and any script your doctor may have given you.
B. Not been to MAIC before: you must bring current insurance card, picture ID, previous mammogram for comparison (if done within the Hampton Rhodes area) and a script from your doctor.

DIAGNOSTIC MAMMOGRAM: Diagnostic test; you MUST have a script from your doctor. You or your doctor has found a specific problem (lump, mass, localized pain, nipple discharge). Your doctor has examined the breast(s) and written a detailed script describing the problem.

C. Been seen at MAIC before: you must bring your current insurance card, a picture ID, and a detailed script from your doctor.
D. Not been to MAIC before: you must bring your current insurance card, a picture ID, previous mammogram for comparison (if done within the Hampton Rhodes area) and a detailed script from your doctor.

BREAST ULTRASOUND: Diagnostic test; your doctor has examined the breast(s) in question and written a detailed script describing the problem or the radiologist has recommended an ultrasound based on something seen on a recent mammogram.

E. Been seen at MAIC before: you must bring current insurance card, picture ID, and any script your doctor may have given you if a recent mammogram has not been performed.
F. Not been to MAIC before: you must bring current insurance card, picture ID, previous or recent mammogram (if applicable) and a detailed script from your doctor.

BONE DENSITY: Diagnostic test; you MUST have a script from your doctor with a diagnosis. Do not take a calcium supplement the day of your exam. You must bring your current insurance card and a picture ID.

LATE POLICY: Please arrive 15 minutes early. If you are running late and arrive after your scheduled appointment time, you will be advised that you have become a “work-in”. In fairness to our patients who are on time, we will do your exam(s) but we cannot guarantee how long you may have to wait

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CHESAPEAKE
300 MEDICAL PARKWAY
SUITE 302
CHESAPEAKE, VA 23320-4985
757-312-8403
FAX 757-312-8314

FIRST COLONIAL
1181 FIRST COLONIAL ROAD
SUITE 201
VIRGINIA BEACH, VA 23454-2437
757-228-1600
FAX 757-228-1727

KEMPSVILLE
844 KEMPSVILLE ROAD
SUITE 210
NORFOLK, VA 23502-3951
757-461-6131
FAX 757-461-3897

NEWPORT NEWS
750 MCGUIRE PLACE
SUITE A
NEWPORT NEWS, VA 23601-1675
757-223-5059
FAX 757-223-5664

"CONSENT FORM"

I, ____, hereby give "consent" for the release of the following information to ***Mid-Atlantic Imaging Centers*** as part of their "health care operation" as defined by the Health Insurance Portability and Accountability Act (HIPAA):

____________ Mammogram Films and Reports

____________ Breast Ultrasound Reports

____________ Biopsy/Pathology Reports

Please forward films and/or reports to the ***Mid-Atlantic Imaging Center*** address indicated:

__ 300 Medical Pkwy.	__ 1181 First Colonial Rd.	__ 844 Kempsville Rd.	__ 750 McGuire Pl.
Suite 302	Suite 201	Suite 210	Suite A
Chesapeake, VA 23320	Virginia Beach, VA 23454	Norfolk, VA 23502	Newport News, VA 23606

____
Patient Signature

____
Date of Birth

____
Last 4 digits of Social Security #

NOTE: 5-10% of cancers are not identified by mammography. Dense breast tissue may obscure an underlying neoplasm. False positive reports average 3-5%. A clinically suspicious mass or a dominant lesion should be pursued further regardless of a normal mammogram.

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Financial Policy

Thank you for choosing Mid-Atlantic Imaging Centers as your healthcare facility. We are committed to providing you and your family with the best available Imaging resources. In our ongoing process to make sure that all your medical needs are met, our billing department will be available to discuss our fees and this policy with you should you need additional information.

We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to your testing.

Payments for all services will be due at the time that services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard and Discover. ***As a courtesy to you***, it is the policy of Mid-Atlantic Imaging Centers to bill your insurance carrier, although you are ultimately responsible for the entire bill. As the responsible party, please understand the following:

(PLEASE CAREFULLY READ AND INITIAL THE FOLLOWING)

_____1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with YOU, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurances and "usual and customary" charges. As your Medical Imaging facility, we will only supply factual information to facilitate the claim processing. Also please understand, we will not know if your insurance will cover your testing until the claims have been submitted.

_____2. Fees for services, which include unpaid balances, deductibles and co-payments, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees.

_____3. All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within sixty days, the balance will be due in full from you. If any payment is made directly to you for services billed by Mid-Atlantic Imaging Centers, you recognize an obligation to remit payment to Mid-Atlantic Imaging Centers.

_____4. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Mid-Atlantic Imaging Centers, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

At Mid-Atlantic Imaging Centers, we understand that financial problems may affect timely payment, so we encourage you to communicate with us any such problems and concerns that you have so that we may assist you in keeping your account in good standing. If you have any questions, please call (757) 416-5542 or (757) 461-6131.

I understand the above information and will be responsible for the patient listed below.

Printed Name of Patient ____________________________ **Date:** ________________

Signature of Patient or Responsible Party: _____________________________________

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DIAGNOSTIC MAMMOGRAM AND OR BREAST ULTRASOUND

NAME: ____

ID # ____

REFERRING PHYSICIAN: _____________________________

- **By signing this waiver I give Mid-Atlantic Imaging Centers permission to perform a DIAGNOSTIC mammogram and/or breast ultrasound on my person.**

- **If my insurance company chooses to deny payment for this claim, I understand that *I will be responsible for the charges associated with the service rendered to me by Mid-Atlantic Imaging Centers in full.***

- **MAIC cannot guarantee insurance coverage on any diagnosis given to us by your referring/requesting physician.**
- **These procedures are considered diagnostic exams. Payments from your insurance carrier may be applied toward your annual deductible, if your deductible has not been reached for the year.**
- **Breast “screening” ultrasounds are generally not a covered item by insurance companies and will become patient responsibility.**
- **If you wish to obtain verification from your insurance carrier before having this exam, you may reschedule your appointment with us.**

SIGNATURE: __________________________________

DATE: ____