



LIMITED OR FOLLOW-UP MAMMOGRAPHY QUESTIONNAIRE (Please print)

Date Physician Name SS # Complete Address Birth Date Age Home # Work # For MAWC-IC Use : Acct# X-Ray#

YES NO...ANY HISTORY OF BREAST CANCER / YOU OR FAMILY MEMBER? (Relationship) YES NO... ARE YOU TAKING HORMONES SUCH AS: BIRTH CONTROL PILLS, ESTROGEN, PROGESTERONE, THYROID, OR CORTISONE? (Circle one) YES NO... DO YOU HAVE BREAST IMPLANTS? YES NO... DO YOU HAVE PAIN, DISCOMFORT, OR SORENESS THAT IS "NEW"? YES NO... DO YOU HAVE A LUMP/MASS IN YOUR BREAST THAT IS "NEW" SINCE LAST EXAM? YES NO... DO YOU HAVE DISCHARGE FROM EITHER NIPPLE? (Circle One) YES NO... HAVE YOU EVER HAD BREAST SURGERY? Before Last Exam Since Last Exam YES NO... IS THERE A SIGNIFICANT WEIGHT CHANGE (>10 LBS) SINCE YOUR LAST EXAM? INCREASE DECREASE

DATE OF LAST BREAST EXAM BY YOUR PHYSICIAN

In order to prevent possible irradiation to your unborn child, to the best of your knowledge, do you believe there is a possibility you are pregnant at this time? Yes No

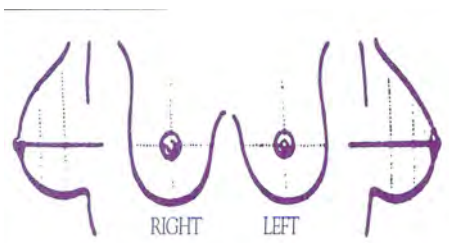
Date of Last Menstrual Period (if applicable)

Signature Date

TO BE COMPLETED BY TECHNOLOGIST

TOLERANCE FOR PROCEDURE: well moderately well poorly

Denied any complaints Machine wiped down SCAR MOLE LUMP PAIN



TECHNOLOGIST:

COMMENTS:



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



MID-ATLANTIC
IMAGING CENTERS

Mammography
Breast Ultrasound
Bone Densitometry



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.



Mammography
Breast Ultrasound
Bone Densitometry



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: _____



(B) Patient Name: _____

(C) Identification Number: _____

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for **(D)** _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **(D)** _____ below.

(D)	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:
Bone Density Study	Medicare will only pay for this service once every 2 years.	\$128.84
Screening Mammogram _____	A. Under age 35 = No payment is allowed for screening. B. Age 35 to 39 – Baseline – Pays for only one screening mammogram between 35 th and 40 th birthday. C. Over age 39 (i.e. 40 and over) = Annual (11 full months have elapsed following the month of last screening).	\$229.00
CAD (Computer Aided Detection)	Medicare does not usually pay for this service	\$29.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **(D)** _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS:	Check only one box. We cannot choose a box for you.
<input type="checkbox"/>	OPTION 1. I want the (D) _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
<input type="checkbox"/>	OPTION 2. I want the (D) _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
<input type="checkbox"/>	OPTION 3. I don't want the (D) _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature: _____	(J) Date: _____
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.