MID-ATLANTIC
IMAGING CENTERS

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

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

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

LANDSTOWN COMMONS
PRINCESS ANNE
3300 PRINCESS ANNE ROAD
SUITE 743
VIRGINIA BEACH, VA 23456
757-301-2500
FAX 757-301-2003

NEWPORT NEWS
750 McGUIRE PLACE
SUITE A
NEWPORT NEWS, VA 23606
757-223-5059
FAX 757-223-5654

BREAST QUESTIONNAIRE

(Please Print)

Date_____ Referring Physician_____

Name_____ Birth Date_____

Complete Address _____

Age_____ Home/Cell #: _____Work #:_____

For MAIC Use : ACCOUNT#_____

___YES ___NO... HAVE YOU EVER HAD A MAMMOGRAM? WHERE? _____
___YES ___NO... DO YOU HAVE FAMILY MEMBER(S) WITH BREAST CANCER?
(Relationship to you)_____

___YES ___NO... HAVE **YOU** EVER HAD CANCER? TYPE? _____
___YES ___NO... HAVE YOU EVER HAD CHEMO OR RADIATION THERAPY FOR BREAST CANCER?

___YES ___NO... HAVE YOU EVER BEEN TOLD YOU HAVE "DENSE" GLANDULAR BREAST TISSUE?
___YES ___NO... ARE YOU TAKING HORMONES SUCH AS; *BIRTH CONTROL PILLS, ESTROGEN OR PROGESTERONE (HRT), THYROID OR CORTISONE MEDICATION? (Circle all that apply)*

___YES ___NO... DO YOU HAVE BREAST IMPLANTS? SALINE SILICONE (Circle One)
___YES ___NO... HAVE YOU HAD BREAST REDUCTION SURGERY?

(Circle One or Both)

___YES ___NO... DO YOU HAVE DISCHARGE (Color) _____ FROM YOUR NIPPLE(S) THAT IS NEW? Right Left
___YES ___NO... DO YOU HAVE A LUMP/MASS IN YOUR BREAST THAT IS NEW? Right Left
___YES ___NO... HAVE YOU HAD PREVIOUS BREAST SURGERY OR BREAST BIOPSY? Right Left
DATE(S) _____RESULT(S)_____

___YES ___NO... IS THERE A SIGNIFICANT WEIGHT CHANGE (> 10 lbs) SINCE YOUR LAST EXAM?
INCREASE_____ DECREASE_____

DATE YOUR PHYSICIAN LAST EXAMINED YOUR BREAST(S) _____

AGE @ FIRST MENSTRUAL PERIOD_____ MENOPAUSE ONSET OR HYSTERECTOMY (*Circle one*) AGE_____

OF PREGNANCIES_____ AGE @ FIRST LIVE BIRTH _____ DID YOU BREAST FEED?_____

ARE YOU CURRENTLY BREAST FEEDING? YES NO (*Circle one*)

HAVE YOU BREAST FED IN THE PAST 6 MONTHS? YES NO (*Circle one*)

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)_____

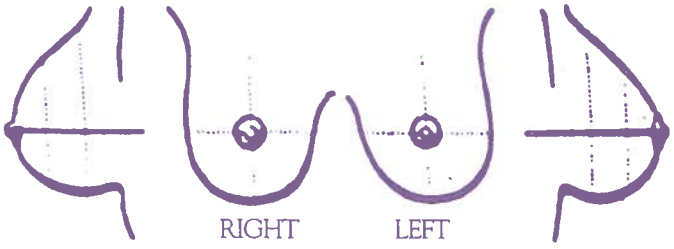
Signature **Date**

TO BE COMPLETED BY TECHNOLOGIST

TOLERANCE FOR PROCEDURE:
___well ___moderately well ___poorly

_____Denied any complaints
_____Machine wiped down

Mark the following: SCAR MOLE LUMP PAIN



TECHNOLOGIST: _____

COMMENTS:_____

MID-ATLANTIC IMAGING CENTERS

Mammography
Breast Ultrasound
Bone Densitometry

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
A division of Mid-Atlantic Women's Care, PLC
6353 Center Drive, Suite 100
Norfolk, VA 23502

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **Date of Birth**: _____
Phone: **H)** _____ **Phone: C)** _____
Address: _____ **City/State/Zip**: _____
Please Note: Copy Fee May Be Charged For Medical Record

Above listed patient authorizes the following healthcare facility to make record disclosure:
Facility Name: Mid-Atlantic Imaging Centers **Facility Phone**: _____
Facility Address: _____ **Facility Fax**: _____
City, State, Zip: _____

Date and Type of Information to Disclose:
- ❑ 2 years prior from last seen
- ❑ Dates Other: _____
- ❑ Specific Information Requested: _____

The purpose of disclosure is:
- ❑ Change of Insurance or Physician
- ❑ Continuation of Care (e.g., VA Med Ctr)
- ❑ Referral or other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified as stated in **Sec. 164.524.**

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:
Release to: ❑ Mid-Atlantic Imaging Centers_____
Address: _____
City, State, Zip: _____ ❑ Please mail records
Fax: _____ Phone: _____ ❑ Please fax records

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Practice's Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to any insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, even, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Practice's Privacy Officer.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____
Signature of Patient/Parent/Guardian or Authorized Representative (Guardian or Authorized Representative must attach documentation of such status) Date

_____ _____
Printed Name of Authorized Representative Relationship/Capacity to Patient

_____
Address and telephone number of authorized representative

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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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***(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 **Screening Mammogram** _____ **CAD (Computer Aided Detection)**	Medicare will only pay for this service once every 2 years. **A.** Under age 35 = No payment is allowed for screening. **B.** Age 35 to 39 – Baseline – Pays for only one screening mammogram between 35th and 40th birthday. **C**. Over 40 = Annual (1 year and 1 day must have elapsed following last screening). Medicare does not usually pay for this service	$265.00 $323.00 $37.00

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.**
❑ **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. ❑ **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**. ❑ **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:**

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

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FAX 757-461-3897

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3300 PRINCESS ANNE ROAD
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VIRGINIA BEACH, VA 23456-2605
757-301-2500
FAX 757-301-2003

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

DIAGNOSTIC MAMMOGRAM AND/OR DIAGNOSTIC BREAST ULTRASOUND

NAME: _____

ID # _____

REFERRING PHYSICIAN: _____

- **By signing this waiver I give Mid-Atlantic Imaging Centers permission to perform a DIAGNOSTIC mammogram and/or diagnostic 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.**
- **If you wish to obtain verification from your insurance carrier before having this exam, you may reschedule your appointment with us.**

SIGNATURE: _____

DATE: _____

NOTE: 5-10% of cancers are not identifed 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.