



## Automatic Breast Ultrasound system (ABUS) Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

Physician \_\_\_\_\_ Daytime Phone# \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_

For MAIC Use: Acct# \_\_\_\_\_

.....  
Have you ever had a mammogram? \_\_\_\_\_ Where? \_\_\_\_\_ Date? \_\_\_\_\_

What is your Breast Density Level?    A\_\_    B\_\_    C\_\_    D\_\_

Have you ever had a diagnostic breast ultrasound? \_\_\_\_\_ Where? \_\_\_\_\_

Have you ever had a breast biopsy or aspiration of a breast cyst? \_\_\_\_\_ Date? \_\_\_\_\_

Have you ever had breast reduction surgery? \_\_\_\_\_

Have you ever been diagnosed with Breast Cancer? \_\_\_\_\_ Date? \_\_\_\_\_

.....  
**TECHNOLOGIST'S COMMENTS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Technologist:** \_\_\_\_\_



**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?) \_\_\_\_\_

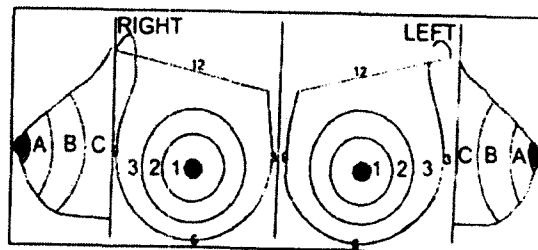
How long have you been aware of this lump? \_\_\_\_\_ Is the lump tender? \_\_\_\_\_

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: \_\_\_\_\_



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*  
844 Kempsville Road, Suite 210, 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, event, 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



**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:** \_\_\_\_\_

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

**LANDSTOWN COMMONS**  
3300 PRINCESS ANNE ROAD  
SUITE 743  
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:** \_\_\_\_\_

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: \_\_\_\_/\_\_\_\_/\_\_\_\_



**CHESAPEAKE**

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

**FIRST COLONIAL**

1181 FIRST COLONIAL ROAD  
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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

**LANDSTOWN COMMONS**

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

## AUTOMATED BREAST ULTRASOUND SYSTEM

**NAME:** \_\_\_\_\_

**ID #** \_\_\_\_\_

**REFERRING PHYSICIAN:** \_\_\_\_\_

- **By signing this waiver I give Mid-Atlantic Imaging Centers permission to perform a bilateral ABUS breast ultrasound due to the density level of my breast tissue.**
  
- **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.**
- **The procedure is very new and considered a “screening” exam used as an adjunct to mammography by the FDA.**
- **You may be required to pay a co-pay or payment in full should your insurance carrier apply this service toward your annual deduction.**
- **Breast “screening” ultrasounds are generally a covered item by most insurance companies.**
- **If you wish to obtain verification from your insurance carrier before having this exam, you may reschedule your appointment with us.**

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_