



**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**

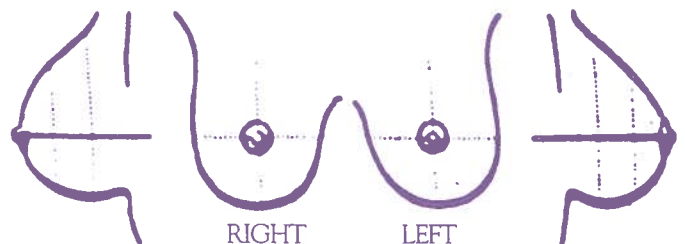
TOLERANCE FOR PROCEDURE:  
\_\_\_ well \_\_\_ moderately well \_\_\_ poorly

\_\_\_ Denied any complaints  
\_\_\_ Machine wiped down

Mark the following: SCAR MOLE LUMP PAIN

TECHNOLOGIST: \_\_\_\_\_

COMMENTS: \_\_\_\_\_





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

**(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.

<b>(D)</b>	<b>(E) Reason Medicare May Not Pay:</b>	<b>(F) Estimated Cost:</b>
<b>Bone Density Study</b>	Medicare will only pay for this service once every 2 years. <b>A.</b> Under age 35 = No payment is allowed for screening. <b>B.</b> Age 35 to 39 – Baseline – Pays for only one screening mammogram between 35 <sup>th</sup> and 40 <sup>th</sup> birthday. <b>C.</b> Over 40 = Annual (1 year and 1 day must have elapsed following last screening). Medicare does not usually pay for this service	\$265.00
<b>Screening Mammogram</b>  _____		\$323.00
<b>CAD (Computer Aided Detection)</b>		\$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:** \_\_\_\_\_

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.

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 757-301-2003

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