Here is a checklist of what you'll need to bring to your initial visit. Please read each item carefully, and call the office with any concerns or questions.

1-The attached forms:
Please complete the following pages as best you can. We will be glad to assist you in the office with any item about which you have questions. If you prefer to complete the forms in the office before your visit, please arrive about 30 minutes in advance of your appointment time to have ample time to complete the forms and be registered. If you would like more personal help with these forms, our Medical Assistant will be most happy to assist you in completing them when you come in, so just come in a bit early.

2-Your X-ray films:
If you have had any ultrasound or mammogram x-rays done, please bring the actual films (not just the reports, but the images themselves) to your appointment. We can accept ultrasound exams on a CD, but not mammogram images, so if you have had a mammogram, the imaging center must print those images onto actual x-ray film. Please call the imaging center where you had your films done at least 2 working days ahead and ask them to get these ready for you to pick up in advance of your appointment. You may bring these with you at the time of your appointment.

3-Your insurance card:
If you do not have health insurance, please let us know in advance of your appointment, so we can work with you on mutually acceptable arrangements.

4-A photo I.D.

5-A written referral from your referring physician IF ONE IS REQUIRED by your insurance.

We do accept credit cards as well as checks or cash for copayments and other fees.

Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) ______________________ (First) ___________ (MI) _____ Previous Name ______________________

Address Line 1 ____

City, State ______________________________ ZIP __________________

Home Phone ____________________ Cell No. __________________ Work Phone ________________ Ext. __________

Primary Care Provider (PCP) _______________________________ Referring Provider ___________________________

Rendering Provider Name (this practice) ______________________________ E-Mail Address: __________________________

Date of Birth MM ______/DD ________/YYYY ___________ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other ☐ ________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-______-________ Employer Name ______________________________

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name ______________________________ First Name ______________________

Phone Number ______________________________________ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient __________________________________ ☐ Guardian

Address Line 1 ____

City, State ______________________________ ZIP __________________

Home Phone ____________________________ Work Phone ___________________________ Ext. ______________

Referring Provider Name ____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) ______________________ (First) ______________________ (MI) __________

Guarantor Account Number ______________________ Date of Birth MM ________/DD ________/YYYY __________

Social Security Number _______-_____-_______ Telephone ____________________

E -Mail Address ______________________________ Sex ☐ F – Female ☐ M - Male

Address Line 1 ____

City, State ______________________________ ZIP __________________

Employer ____ Employer Phone Number ____________________

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number ____ (______) ______________

Name of Insured ____________________________________ Patient Relationship to Insured ________________

Subscriber ID (Policy Number) ________________ Group ID ________________ Copay Amount ________________

Effective Date __________________ Termination Date ______________ Date of Birth MM ______/DD ______/YYYY _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number ____ (______) ______________

Name of Insured ____________________________________ Patient Relationship to Insured ________________

Subscriber ID (Policy Number) ________________ Group ID ________________ Copay Amount ________________

Effective Date ____________________ Termination Date ______________ Date of Birth MM ______/DD ______/YYYY ____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature ____ ***Date*** ______________

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Reston
Breast Care Specialists

We are committed to providing you with the best possible care. If you have medical insurance, we strive to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policies.

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE PROVIDED

We accept cash, checks and Visa/MasterCard. We will be happy to process claims for those PPO's and HMO's with which we participate, but you will be expected to pay any copay or percentages of deductibles at the time of service. We participate with most major carriers and therefore will file the claim on your behalf. For other insurance companies, you are responsible for all fees at the time services are provided. We will provide you with information so you may file with your insurance company.

We must emphasize that as medical providers, our relationship is with you and not your insurance company. All charges are your responsibility from the date the services are rendered. If someone else is presumed liable for a bill, such as a divorced spouse or parent, we will look to the patient or if a minor, the guardian, for payment of services. We gladly provide you with a receipt for payment. We realize that temporary financial problems may effect timely payment of your account. If such problems do arise, we encourage you to contact us promptly, and prior to your office visit, for assistance in the management of your account.

Returned checks and balances older than thirty days may be subject to additional collection fees. We will gladly discuss your charges prior to your visit, as well as, any relating to your insurance. You must realize, however, that:

1- Your insurance is a contract between you, your employer, and the insurance company.
2- Not all services are a covered benefit in all contracts. You may wish to contact your insurance carrier for information regarding coverage. For example: Many insurance companies do not cover routine exams or supplies, such as crutches.

Please help us by updating your registration sheet with the receptionist when changes occur such as new employer, insurance or new home address. If you have any question about our office, please do not hesitate to ask. We are here to help you.

Initials ___________

_______________________________________ agree that I am fully responsible for my bill if at any time my insurance denies payment. I am responsible for making sure my insurance is currently active and participating with the provider that I am seeing. If I am seeking urgent care treatment, I agree that I will pay the urgent care co-pay that has been established by my insurance company. I also agree that if I have a balance after my insurance has paid, that I will be responsible for the remaining balance due.

_______________________________________ ______________________________

Patient Signature Date

How did you hear about our office?

Physician Referral (Name) ____________ Insurance Assignment ______________
Emergency Room ____________ Personal Reference ______________
Mailbox Flyer ____________ Signs ______________

TO REORDER CALL SAFEGUARD (804) 355-2879 • FAX (804) 359-6332 • lmeagher@cavtel.net www.SafeguardJack.com W09SF001105M 9/09

The following form is used for you to tell us with whom we may communicate regarding your care, other than the physician who referred you, or your insurance company.

If we are allowed by you, for instance, to communicate with your spouse or significant other regarding your medical information, you may list that person on the form, and their contact number.

Just to be clear, we do not initiate any contact with anyone on this form, unless you as the patient as us to do so for some reason. If someone other than you calls the office asking any information about you, we check this form and see if it is permitted by you for us to discuss your care with that person, before divulging any information at all. If the person calling isn't listed here, no information will be divulged, and if the person calling doesn't know your password, no information will be divulged.

You may also specify if it is permitted to leave any phone messages/voice mails, and if so, at which phone numbers.

It's all about protecting your privacy!

Reston
Breast Care Specialists

PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name ______________________________ DOB __________

Account or Med. Rec. #______________________

By signing this paper below, I give permission to the person(s) listed in the table documented to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Date of Permission	Name of Individual & Relationship to Patient	Comments/Instructions *(i.e.: may pick up meds, may disclose test results, etc)*	Patient/ Guardian Initials

THE PHYSICIANS/STAFF HAS MY PERMISSION TO: (Please check all boxes that apply)

☐ Leave message at home with my spouse or:

NAME: ______________________________

RELATIONSHIP: ____________________ DOB:__________

☐ Leave message on cell phone. Cell phone number: ____________________

☐ Leave message at work. Work phone number: ____________________

☐ Leave message on voicemail. Phone number: ____________________

☐ Leave a detailed message on answering machine. Phone number: ____________________

In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

Patient Chosen Identifier/Password: ______________________________

______________________________ ____________________
Signature of Patient or Legal Guardian Date

______________________________ ____________________
Printed Name of Patient or Legal Guardian Relationship *(if not self)*

TO ORDER CALL SAFEGUARD. (804) 355-2679 • FAX (804) 359-8332 JMeagher@GoSafeguard.com

The next page is a release form to allow us to send your actual medical records to someone (another physician, etc.) other than your referring/regular physician.

We know you haven't asked for your records to be sent anywhere! However, if you should ever wish for us to do so, we cannot do that without your written consent.

The management group supporting Reston Breast Care Specialists deems that it is more convenient for the patient if we keep your signature on file on a blank request form, such that if you ever do need records transferred, all you need to do is call us, and we complete the form at your direction, and save you time and the inconvenience of having to come back to the office to give us a signature, or the wait time to mail signature forms out and back.

If you do not feel comfortable in signing a blank form, please don't do it. But if you would like this to be kept in your records, you only need to fill in the top line (Name, date, social security number), and sign and date the very bottom.

As always, please just ask if you have any questions.

Reston
Breast Care Specialists

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient's Name:	**Birth Date:**	**Social Security Number:**
Provider's Name:	**Recipient's Name:**	
Provider's Address:	**Address 1:**	
	Address 2:	
	City:	**State:** **Zip:**

Expiration Date or Event: This authorization will expire on the following expiration date (or) expiration event:
Date: **Event:**

Purpose of Disclosure:

Description of Information to be Used or Disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.
☐ No, then you may check as many items below as you need.

Description:	**Date of Service:**	**Description:**	**Date of Service:**	**Description:**	**Date of Service:**
☐ All PHI in Medical Record		☐ Operative Information		☐ Labor/Delivery Summary	
☐ Admission Form		☐ Cath Lab		☐ OB Nursing Assess	
☐ Dictation Reports		☐ Special Test/Therapy		☐ Postpartum Flow Sheet	
☐ Physician Orders		☐ Rhythm Strips		☐ Itemized Bill:	
☐ Intake/Output		☐ Nursing Information		☐ UB-92 Claim:	
☐ Clinical Test		☐ Transfer Forms		☐ Other:	
☐ Medication Sheets		☐ ER Information		☐ Other:	

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary. However, refusal to sign will render this form invalid.
2. I understand that protected health information may include information and records protected under Federal and State Law such as; alcohol, drug abuse, mental health, AIDS or HIV testing or treatment.
3. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
4. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
5. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
6. There may be a reasonable fee to obtain a copy of the information being requested on this form.
7. I get a copy of this form after I sign it.
8. Note: There will be a charge for records in accordance with the VA code 8.01-413 $0.50 (Per page up to 50 pg) Additional $0.25 per page (from page 51 & up) + actual postage.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:

Section C: Required Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/ or Personal Representative:	**Date Signed:**
Printed Name of Patient/Guardian/ or Personal Representative:	**Relationship of Personal Representative to Patient:**

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Reston Breast Care Specialists

Consent for Treatment and Payment Agreement

I hereby authorize Reston Breast Care Specialists to use and/or disclose my health information which specifically identifies me or which can reasonable be used to identify me to carry out my treatment, payment and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to Reston Breast Care Specialists of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to Reston Breast Care Specialists, all insurance or third party payments that I receive for services rendered to me immediately upon receipt. Patient Initial: ___________

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to Reston Breast Care Specialists. Patient Initial: ___________

I request this authorization also apply to all other insurance. Patient Initial: ___________

I acknowledge that I have been given Reston Breast Care Specialists Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Facility Privacy Official. Patient Initial: ___________

RELEASE OF MEDICAL INFORMATION

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below. I understand that I may request individuals to leave the exam room at any time.

Name of Person who is Authorized to receive information	Release info (please circle)	Allowed in exam room (please circle)
___________________________	Y N	Y N
___________________________	Y N	Y N
___________________________	Y N	Y N

***If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from re-disclosure**

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature____

Date___________________________ **Patient Date of Birth**___________________________

MEDICAL HISTORY FORM FOR MALE PATIENTS

NAME_______________________________ AGE_____ DATE COMPLETED_______________

PRIMARY CARE PHYSICIAN____________________________

WHO REFERRED YOU? __________________________________

I. WHAT IS THE REASON FOR YOUR VISIT?

____

____

II. Please list your past medical illnesses:

____

____

____

____

Please list previous surgical procedures and dates:

____

____

____

____

Have you ever smoked? ____Yes ____No If yes, how many packs per day?_____
For how long? ____years
If you no longer smoke, how long ago did you quit? _________

How many alcoholic beverages do you consume weekly? ________

Please list your race or ethnic group________________________________

Are you of Ashkenazi (Eastern European Jewish) descent? _____No ____Yes

III. Family History

_____There is no one in my family that I know of with a history of cancer.

My family history is positive for (please list relationship to you):

Breast cancer ____

Ovarian cancer ____

Uterine cancer ____

Colon cancer ____

Other cancer ____

Has anyone in your family had genetic testing for breast cancer? (BRCA 1 or 2 testing)

_____Yes   _____No   Result if known:___________________________________