BREAST HISTORY

Today's Date: _____/_____/_____ ID#: _____

Name: _____ Date of Birth: _____/_____/_____ Age: _____

Pregnant? YES ☐ NO ☐ Last menstrual (if applicable): _____/_____/_____

Breast feeding? YES ☐ NO ☐ Age at First Period: _____

Age at First Delivery: _____ Hysterectomy? YES ☐ NO ☐

# of Deliveries: _____ Age of menopause: _____

Do you take hormones? YES ☐ NO ☐ How long? _____

NEW BREAST PROBLEMS (please describe):

☐ NONE _____

RISK FACTORS

Have you had any kind of cancer? ☐ YES ☐ NO If yes, specify: _____

Family history of breast cancer?

☐ NONE OR ☐ Mother Approximate age at diagnosis: _____

☐ Sister Approximate age at diagnosis: _____

☐ Daughter Approximate age at diagnosis: _____

☐ Other Approximate age at diagnosis: _____

BREAST SURGERY

☐ NONE OR

☐ Biopsy	☐ Left	Year_____	☐ Right	Year_____
☐ Lumpectomy (not cancer)	☐ Left	Year_____	☐ Right	Year_____
☐ Lumpectomy (cancer w/ radiation)	☐ Left	Year_____	☐ Right	Year_____
☐ Mastectomy	☐ Left	Year_____	☐ Right	Year_____
☐ Implants	☐ Left	Year_____	☐ Right	Year_____
☐ Reduction	☐ Left	Year_____	☐ Right	Year_____

PREVIOUS MAMMOGRAMS

☐ NONE OR Date of last mammogram: _____

Where was it done: _____

OFFICE USE ONLY

☐ Bilat ☐ Uni ☐ Right ☐ Left

☐ Baseline ☐ Follow up

☐ Screening ☐ Diagnostic

☐ Sch. For sono ☐ CAD

Comments:_____

_____

R.T.(R)(M) _____

TECHNOLOGIST

PAREDES INSTITUTE FOR WOMEN'S IMAGING, P.C.

4480 COX ROAD, SUITE 100
GLEN ALLEN, VA 23060

2530-C GASKINS ROAD
RICHMOND, VA 23238

Referring Physician: _____

How did you find us? ☐ Newspaper ☐ Radio ☐ Magazine ☐ Physician _____

PATIENT INFORMATION **Required from all patients**				**PLEASE PRINT CLEARLY**
Last Name	First Name			M.I.
Mailing Address – Street	City	State		Zip
Home Phone	Employer's Phone	Cell Phone		
Employer	Employer's Address			
Date of Birth / Age / Sex	Social Security #	Marital Status		
Email				

PRIMARY SUBSCRIBER INFORMATION **COMPLETE THIS SECTION ONLY IF PATIENT IS NOT THE PRIMARY SUBSCRIBER.**			**PLEASE PRINT CLEARLY**
Last Name	First Name		M.I.
Mailing Address – Street	City	State	Zip
Home Phone	Employer's Phone	Cell Phone	
Social Security #	Patient's Relationship to Primary Subscriber (circle one) Self Spouse Child Other	Date of birth	

Authorization and Assignment (Required from all patients)

I authorize the Paredes Institute for Women's Imaging to release to my insurance company any information as required. I authorize payment of benefits directly to the Paredes Institute for Women's Imaging. understand that am financially responsible to the Paredes Institute for Women's Imaging for charges not covered by this assignment. In the event of default, I agree to pay all costs of collection including reasonable attorney's fees. This authorization and assignment will remain in effect until a notification of change is received by the Paredes Institute for Women's Imaging, P.C.

Print Name: _____

Signature: _____ Date: _____

Medicare Long-Term Signature Agreement **(For Medicare Patients ONLY)**

I authorize the Paredes Institute for Womens Imaging to release information needed for Medicare Claims to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers.

Print Name: _____

Signature: _____ Date: _____

PLEASE READ WITH CARE AND ATTENTION

THE PAREDES INSTITUTE FOR WOMEN'S IMAGING, P.C.

4480 COX ROAD, SUITE 100
GLEN ALLEN, VA 23060

2530 GASKINS ROAD, SUITE C
RICHMOND, VA 23238

Patient's Name: _____

A **screening (annual) mammogram** is performed on women **without** symptoms, and is used to look for any abnormalities.

If an abnormality is detected, "additional views", or other procedures will be needed like (diagnostic mammogram, 3D diagnostic mammogram and/or an ultrasound) to further evaluate it. These procedures are usually applied to a patient's health insurance deductible (all plans differ) which may or may not incur additional charges. Please note that these procedures are not a part of your screening (annual) mammogram and may not be covered by your insurance.

If **"additional views"** are needed, we can proceed at the same visit. This will save you from having to return on a different day. Your insurance company **may** or **may not** cover a same day diagnostic procedure.

If you need or prefer to return for the diagnostic mammogram on a different day, the same rules would apply regarding insurance coverage. A co-pay may be required based on your insurance policy.

I UNDERSTAND THE ABOVE INFORMATION: _____
Patient Signature

I prefer to leave after my screening mammogram today and return for a diagnostic mammogram if needed. I understand that I will not meet the doctor but the mammogram will be read today. I will be notified by phone within 24 hours if any **"additional views"** or tests are needed and will be given priority scheduling.

Patient's Signature: _____ **Date:** _____

I prefer to **wait** while the mammogram is read and will have **"additional views" (diagnostic)** today if needed.

Patient's Signature: _____ **Date:** _____

It is our policy to return outside films to the facility from which they were sent. If you wish to keep your outside films please notify the technologist.

PAREDES INSTITUTE FOR WOMEN'S IMAGING, P.C.

4480 COX ROAD, SUITE 100
GLEN ALLEN, VA 23060

2530-B & C GASKINS ROAD
RICHMOND, VA 23238

OUR FINANCIAL POLICY

Thank you for choosing the Paredes Institute for Women's Imaging as your healthcare provider. We are committed to the complete and compassionate care of your health. Please understand that payment of your bill is considered to be a part of your treatment. The following is a statement of our Financial Policy that we ask you to read and sign prior to treatment.

WE REQUEST THAT ALL PATIENTS COMPLETE THIS INFORMATION BEFORE SEEING THE DOCTOR.

PAYMENT (i.e. – co-pay or self-pay) IS DUE IN FULL AT THE TIME OF SERVICE

WE ACCEPT CASH, CHECK, MOST MAJOR CREDIT CARDS, DEBIT CARDS, AND/OR PATIENT EASY PAY PLAN.

Regarding Insurance

We may accept assignment of insurance benefits. However, we do require that all co-payments be made at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and an original insurance card at each visit to copy and keep on file. **Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.** You will be responsible for these balances. You agree to obtain an insurance referral prior to your appointment. I will pay at the time of service in full for any procedure requiring a referral, if a referral is not on file for today's visit. I will make this office aware of any insurance coverage change prior to my appointment.

Initial _____

Adult and Minor Patients

Adult patients are responsible for full payment at time of service. The adult accompanying a minor and/or the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard or payment by cash or check at time of service has been verified.

Initial _____

Returned Checks

There will be a $50 returned check fee on all returned checks. In the event that a check is returned for insufficient funds, we will call your bank to verify funds for any future checks that are presented for payment on your account.

Initial _____

Collection Fees

In the event that your account is turned over to a collection agency, you will be responsible for all collection costs including reasonable attorney's fees (if applicable).

Initial _____

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. By signing below, you agree that you have read, understand, and agree to our Financial Policy.

X _____ _____
Signature of Patient or Responsible Party Date

X_____ _____
Signature of Co-Responsible Party Date

MEDICAL INFORMATION PRIVACY FORM

THE PAREDES INSTITUTE FOR WOMEN'S IMAGING, P.C.

4480 COX ROAD, SUITE 100
GLEN ALLEN, VA 23060

2530 GASKINS ROAD, SUITE C
RICHMOND, VA 23238

Our Notice of Privacy Practices provides information about how we may use and disclose Private Healthcare information (PH) about you. As provided in our notice, the terms of our notice may change. If we change our notice, you will be given the revised copy.

I, _____ (print patient name) have received a copy of the Paredes Institute for Women's Imaging Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to the Medical Practice if I do not understand any information contained in the Notice of Privacy Practices.

Below, please provide your telephone number(s) and whether a message regarding your healthcare may be left at that number.

Home Phone: _____ Message: Yes ☐ No ☐

Cell Phone: _____ Message: Yes ☐ No ☐

Work Phone: _____ Message: Yes ☐ No ☐

Medical information may be disclosed to the following:

_____	_____	_____
Authorized Representative of Patient	Relationship	Phone Number
_____	_____	_____
Authorized Representative of Patient	Relationship	Phone Number

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For continuity of care, medical records are faxed from our facility to your providers. By signing this form you give us consent to fax your records.

Please provide the name of the physician(s) you would like our office to send your results:

Physician Name: _____

Physician Name: _____

Physician Name: _____

_____	_____
Patient Signature (Print)	Patient Signature

_____
Date