PARADES 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 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 Women's 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_____

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 to your insurance company, healthcare providers and whomever you authorize below. 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

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To continue your care, please sign an authorization to fax your records to your provider.

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 _____

Rev. 1/27/2017

PATIENT HISTORY

MR (office use)_____ **TODAY'S DATE** _____

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?_____

Date of Last medical Exam_____

Any Abnormal Breast Findings or Recommendations by your Physician _____

PREVIOUS MAMMOGRAMS: NO ***OR*** Date of last mammogram:_____ Where was it done:_____

NEW Breast Problem (please describe): _____

NONE (annual check-up)

TECHNOLOGIST TO COMPLETE

Do you examine your breasts YES NO Not Consistently

RISK FACTORS

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

Family history of breast cancer?

NONE or

Mother Approximate age of diagnosis: _____

Sister Approximate age of diagnosis: _____

Daughter Approximate age of diagnosis: _____

Other Approximate age of diagnosis: _____

BREAST SURGERY

NONE OR

Needle Biopsy Left (X's)___Year_____ Right (X's)____Year_____

Surgical Biopsy (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_____

Comments:_____

RT(R) (M) Initials_____ Radiologist has read the above information (Signature).____

INFORMATION ABOUT YOUR MAMMOGRAM

Dear Patient,

Mammograms are typically ordered in two categories: Screening and Diagnostic.

SCREENING

A screening mammogram (annual) Is performed yearly in healthy women starting with a base line between age 35 and 40, then annually after the age of 40. Two images of each breast are obtained. This can be done using 2D (digital) or 3D (tomosynthesis) imaging.

DIAGNOSTIC

A diagnostic mammogram is performed for any of the following reasons: a palpable lump, feeling a thickened area, nipple discharge, skin changes, focal pain in the breast, a recall from an abnormal screening mammogram, a scheduled early follow-up (less than 1 year), or a personal history of breast cancer.

ADDITIONAL VIEWS OR ULTRASOUND

With either a screening or a diagnostic mammogram, additional images may be needed by the Radiologist to examine, in more detail, an area seen on the initial pictures. This is not unusual and does not mean you have a breast cancer. The Radiologist will decide what images and/ or ultrasound is needed. The extra pictures may be done using 2D or 3D imaging depending on what the physician needs to complete your work-up and be certain an abnormality is not missed.

We will submit all charges incurred from your exam to your insurance for you.

Diagnostic, Additional Views and/or Ultrasound 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.

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.

Please sign below that you understand all of this information and your questions were answered.

Patient Signature Date: _____

OFFICE USE ONLY

(Please initial when above information has been reviewed with patient)

TECHNOLOGIST _____ ***PATIENT*** _____