University Diagnostic Institute Winter Park

Center for Advanced Medical Diagnosis

MAMMOGRAM SCREENING FORM:

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

Address: _____
Street City ST ZIP

Phone #_____

1. Are you PREGNANT now or is there a possibility that you could be pregnant? [ ] YES [ ] NO
2. How many children have you had? _____ How old were you when you had your first child? _____
3. Have you had a prior mammogram? [ ] YES [ ] NO If yes, when? _____ and where _____
4. Are you having any NEW breast problems NOW? [ ] YES [ ] NO IF YES, mark the problem (s) below.
   a. Distinct lumps in either breast? [ ] Right [ ] Left
   b. Lumpiness (fibrocystic changes)? [ ] Right [ ] Left
   c. Discomfort, pain or soreness? [ ] Right [ ] Left
   d. Discharge from nipple? [ ] Right [ ] Left
5. Are you taking Hormones? [ ] Yes [ ] No If Yes, for how long? _____
6. Have You had cancer of the: [ ] None [ ] Breast [ ] Uterus [ ] Ovaries [ ] Other _____
7. Do you have a FAMILY HISTORY of breast cancer? [ ] YES [ ] NO IF YES, please fill in boxes:
   [ ] Mother Age ____ [ ] Sister Age ____ [ ] Daughter Age ____ [ ] Grandmother Age ____ [ ] Aunt Age ____ [ ] Cousin Age ____
8. Please mark if YOU have previously had any of the Breast Procedures below: [ ] NONE

A. Needle Biopsy [ ] Right [ ] Left When? _____
B. Cyst Aspiration [ ] Right [ ] Left When? _____
C. Reduction/ Lift [ ] Right [ ] Left When? _____
D. Mastectomy [ ] Right [ ] Left When? _____
E. Surgical Biopsy [ ] Right [ ] Left When? _____
F. Implants [ ] Right [ ] Left When? _____
G. Lumpectomy [ ] Right [ ] Left When? _____
H. Radiation [ ] Right [ ] Left When? _____

Patient Signature: _____ Date: _____

I hereby declare that the information provided in this form is true and complete to the best of my knowledge.

To be completed by the Technologist:

Exam: _____

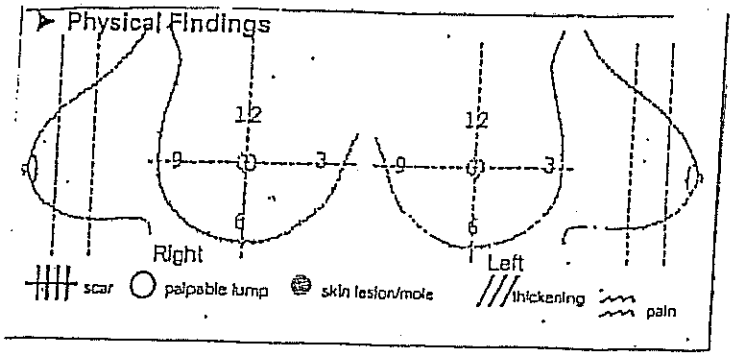
# of Images taken; _____

Clinical Comments: _____

_____

Diagnosis: _____

Tech Initials:_____



111 North Lakemont Avenue – Winter Park, FL 32792
(407) 975-3315 – Fax: (407) 691-0316

University Diagnostic Institute Winter Park

Center for Advanced Medical Diagnosis

OUTSIDE FILMS/ RECORDS RELEASE

We need to know if you have had any previous studies done to the area we are scanning today. Our radiologist requires that we have these to compare to the study you are having done. To assist us in obtaining these studies we need your permission to get them from the facility where the images were done at, please complete this release in its entirety.

Patients Name: _____

Social Security #: _____ Date of Birth: ___/___/_____

Name of Center or Hospital where scans were performed:

_____

Type of Films: _____ Date of Service: ___/___/_____

I authorize the above center or hospital to release my films and reports to:

University Diagnostic Institute
111 N. Lakemont Avenue
Winter Park, FL 32792
Phone: (407) 975-3315
Fax: (407)691-0316

Signed:_____ Date: ___/___/_____

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HIPAA COMPLIANCE

I, _____ understand that as a part of my healthcare, University Diagnostic Institute originates and maintains paper and/or electronic records describing my personal health information. I understand that this information serves as a basis for treatment, payment, or healthcare operations.

I have been provided with and have reviewed University Diagnostic Institute's Notice of Privacy Practices. I understand the rights and privileges outlined in the Notice of Privacy Practices and consent to the usage outlined in the Notice of Privacy Practices.

If there is anyone who you would like to have information on you other than yourself, your insurance carrier, or your referring doctor's office please list their name(s) below:

_____

_____

Messages or Appointment Reminders:
Messages will be of a non-sensitive nature, such as appointment reminders. Messages may be left on an answering machine/ service or voicemail system.

May we leave a message at your **home** using practice name Yes [ ] No [ ]
May we leave a message at your **office** using practice name Yes [ ] No [ ]
Do not leave a message: [ ]

Consent:
I fully understand and accept the information of this consent:

_____ _____
Patient/ Guardian Signature Date

FOR OFFICE USE ONLY

[ ] Restrictions requested by patient
[ ] Consent form received and reviewed
[ ] Consent form signature refused by patient
[ ] Consent form placed in the patient's medical record on _____

_____ _____
Staff Signature Date

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NOTICE

As of March 1st, 2012 we will need at least 48 hours notice to have any films picked up. Per our office policy, you will receive one FREE CD of your scan the day of your appointment. Any additional CD's that are requested will be $25.00. If films are needed, there will be a charge of $15.00 per sheet and the average exam is 6 sheets.

When calling in for pick up we will need to know if your doctor prefers a CD or hard copy of films. Please have this information before calling.

I acknowledge that I have read the above notice and will give U.D.I. at least 48 hours notice to obtain any films.

PRINT: _____

SIGNATURE: _____

DATE: _____

Original 4/1/06---Revised 3/1/12

University Diagnostic Institute Winter Park

Center for Advanced Medical Diagnosis

EMERGENCY CONTACT FORM

NAME:_____

RELATIONSHIP:_____

PHONE NUMBER: _____

111 North Lakemont Avenue – Winter Park, FL 32792

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN AND TRANSFER ANY AND ALL RIGHTS, BENEFITS AND CAUSES OF ACTION TO THE ASSIGNEE. This is an assignment of my rights and benefits. In the event my insurance company is obligated to make payment to me upon charges made by the Assignee for its services, and the company fails or refused to make timely, complete payment. I authorize Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize Assignee to compromise, settle or otherwise resolve said cause of action as they see fit.

DIRECTION OF PAYMENT

I hereby authorize and direct you, my insurance company and/or my attorney, to pay University Diagnostic Institute Winter Park ("Assignee"), such sums as may be due and owning Assignee for the services rendered to me both by reason of accident or illness, and by reason of any other bills that are due Assignee. I hereby authorize any insurance company to pay directly to Assignee the amount of this and/or any future bills for service rendered to me and to release any information requested that is pertinent to my case to my insurance company or attorney involved in this case.

LETTER OF PROTECTION IN FAVOR OF PROVIDER

I hereby authorize and direct that my lawyer, if I am represented by counsel, SHALL withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, or any other insurance benefits obligated to reimburse me, or, from any settlement, judgment or verdict on my behalf as may be necessary to reimburse Assignee for services provided to me. I HEREBY FURTHER GIVE AN IRREVOCABLE LIEN to said Assignee against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the Assignee. IN the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Assignee.

PIP LOG & DEC SHEET REQUEST

I HEREBY AUTHORIZE THE ASSIGNEE TO REQUEST A COPY OF THE APPLICABLE INSURANCE POLICY AND DECLARATION PAGE WHICH REFLECTS THE POLICY LIMITS AVAILABLE AT THE TIME OF THIS ACCIDENT, AND THE APPLICABLE PIP LOG TO BE PROVIDED TO THIS ASSIGNEE upon request. This request is authorized pursuant to the terms of my policy as well as Florida Statutes. I hereby authorize this Assignee to request and receive a copy of my pip log periodically as they deem to be necessary.

RESERVATIONS OF BENEFITS

Be further advised that I AM HEREBY PLACING YOU ON NOTICE PURSUANT TO FLORIDA CASE LAW THAT SHOULD YOU (THE INSURANCE COMPANY/CARRIER) DENY, REDUCE OR FAIL TO PAY ANY PART OF, OR AN ENTIRE BILL WHICH WAS SUBMITTED ON MY BEHALF FROM THIS PROVIDER. I (THE ASSIGNOR) AS WELL AS THE ASSIGNEE ARE REQUESTING IN ADVANCE THAT YOU RESERVE, OR "SET ASSIDE", THE AMOUNT YOU REDUCED OR DENIED UNTIL THE DISPUTE IS RESOLVED. Should you submit a check to Assignee which is less that the correct contractural amount, and contains any language referring to payments as :Full and Final Payment", I have instructed Assignee to return the check to you (the Carrier) and consider the bill still due and owing (i.e. a late payment as defined in F.S.627.736). Additionally SHOULD THE REMAINING AMOUNT OF MY BENEFITS APPROACH AN AMOUNT WHERE THERE WOULD BE INSUFFICIENT FUNDS TO PAY THE AMOUNT YOU REDUCED, DENIED OR FAILED TO PAY, PLEASE NOTIFY ME (THE ASSIGNOR) AND THE ASSIGNEE OF THIS FACT. Should my benefits exhaust, please notify me (the assignor) and assignee promptly.

SEVERABILITY CLAUSE

If any term or provision of this Assignment, Lien and Authorization or the application thereof to any person or circumstances shall to any extent to invalid or unenforceable the remainder of this Assignment, Lien and Authorization or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected therby and each term and provision of this Assignment, Lien and Authorization shall be valid and enforced to the fullest extent of the law.

Signature _____ **Date** _____

Print Name _____ **Date** _____