Palm Beach Breast Institute
Breast Care by Design

Patient Information

Last Name ______________________ First Name ______________________ M.I. ________

Date of Birth ______________________ Country of Birth ______________________

Mailing Address ____

City ______________________ State ______________________ Zip ________

Phone ______________________ Cell Phone ______________________

E-mail ____

EMPLOYER

Name of Company ______________________ Contact Person ______________________

Address ____

City ______________________ State ______________________ Zip ________

Phone ______________________ Alternate Phone ______________________

IN CASE OF EMERGENCY

Contact Person ____

Phone ______________________ Alternate Phone ______________________

SPOUSE/SO

Full Name ______________________ Date of Birth ______________________

Spouse/SO Phone ______________________ Spouse/SO Cell Phone ______________________

Spouse/SO Employer ____

REFERRAL INFO

Referred by ____

Please Continue on Page 2

Palm Beach Breast Institute
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Insurance Information

Your Last Name________________________ First Name __________________ M.I. ________

PRIMARY CARRIER

Company Name ____

Group # ________________________ ID # ________________________

Subscriber's Name ____

AUTHORIZATION:

I authorize the release of any medical information necessary to process my claims.

Signature ________________________________ Date ________

SECONDARY CARRIER (IF APPLICABLE)

Company Name ____

Group # ________________________ ID # ________________________

Subscriber's Name ____

AUTHORIZATION:

I authorize the release of any medical information necessary to process my claims.

Signature ________________________________ Date ________

MEDICARE ASSIGNMENT LIFETIME AUTHORIZATION

I request that payment of authorized Medicare Benefits be made on behalf of Robert A. Gardner, M.D.

Signature ________________________________ Date ________

Please Continue on Page 3

Palm Beach Breast Institute
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Breast Cancer Risk Evaluation Questions
Based on NCI - NSABP Breast Cancer Risk Assessment

YOUR INFORMATION

Last Name ______________________________ First Name ________________________ MI __

Age _____ Age at First Period ____ Age at First Birth of Child ____ No of Breast Biopsies ____

Your Race White Black Other __________________________

YOUR MEDICAL HISTORY

Number of Breast Biopsies: _____ Any Biopsy Showing Atypical Hyperplasia? Yes No

Have you had a diagnosis of cancer (Invasive or Ductal Carcinoma In Situ)? Yes No

NUMBER OF RELATIVES WITH BREAST CANCER

Mother ________Sister ________Daughter_______Brother ________ Father _________ Other ________

Please Continue on Page 4

Palm Beach Breast Institute
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Communication Release Form

I hereby give permission to Dr. Robert A. Gardner's Office staff to notify me by telephone of the following:

Appointment Reminder

Remind me of my appointment, either by personal message or recorded message, left on my home phone or cell phone: Yes No

Contact me at work to remind me of my appointment: Yes No

Work Phone Plus Extension (If applicable): ________________________________

Other Information

To leave a message to call Dr. Gardner's office regarding any clinical issues, medical forms, test results, or other information.*

At Home: Yes No

At Work: Yes No

**Note: At no time will detailed information be left by message.*

Permission

I give permission to the individuals listed below to receive information on my behalf:

1. ________________________ 2. ________________________

3. ________________________ 4. ________________________

I understand this form is intended to guard my privacy and is not a general release of information form.

Patient Signature ________________________ Date ____________

Patient Name Printed ________________________

Witness Signature________________________

In case of emergency, please contact:

Name________________________ Home Phone ________________________

Work Phone ________________________ Cell Phone ________________________

Please Continue on Page 5

Palm Beach Breast Institute

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Disclaimer:

This document and information it contains does not constitute legal advice. It is also not a substitute for legal or other professional advice. Users should consult their own legal counsel for advice regarding the application of the law and this document as it applies to the HIPAA regulations.

Notice: Patient Privacy Date______________________

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We may require your written consent before we use or disclose to others your medical information for purpose of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting or copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosure of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact Agata M. Vicay, Administrator of our office, at (561) 881-9100.

If you would like to receive the complete version of the Notice of Privacy Practices, please ask us and we will gladly supply yo with one.

Form April 14, 2003 A.V.

Patient Signature ______________________________ Date ______________________

Printed Name ______________________________

Please Continue on Page 6

Palm Beach Breast Institute
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Important Statement

"...UNDER FLORIDA LAW, PHYSICIANS ARE GENERALLY REQUIRED TO CARRY MEDICAL MALPRACTICE INSURANCE OR OTHERWISE DEMONSTRATE FINANCIAL RESPONSIBILITY TO COVER POTENTIAL CLAIMS FOR MEDICAL MALPRACTICE.

YOUR DOCTOR,

ROBERT A. GARDNER,

HAS DECIDED NOT TO CARRY

MEDICAL MALPRACTICE INSURANCE.

THIS IS PERMITTED UNDER FLORIDA LAW SUBJECT TO CERTAIN CONDITIONS. FLORIDA LAW IMPOSES PENALTIES AGAINST NON-INSURED PHYSICIANS WHO FAILED TO SATISFY ADVERSE JUDGMENTS ARISING FROM CLAIMS OF MEDICAL MALPRACTICE.

THIS NOTICE IS PROVIDED PURSUANT TO FLORIDA LAW..."

Prior to submitting any claim or controversy, the parties shall agree to submit the claim or controversy to mediation. "Mediation" is a process in which the parties attempt to resolve a claim or controversy by submitting it to an impartial mediator who facilitates the resolution of a dispute, but who is not empowered to impose a settlement on the parties. Mediation shall also be governed by the AAA rules, regulations, and procedures then in effect.

____
Patient Name

______________________________ ______________
Signature Date

Please Continue on Page 7

Palm Beach Breast Institute
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Medical History

Date_______________Name____

Sex _________Date of Birth ________________________________ Height________ Weight_______

General Health

Good Fair Poor

If not good, please explain____

Have you had a recent physical? No Yes Date __________________

Recent Mammogram? No Yes Date ___________________ Pap Smear? No Yes Date ____________________

Physician ____ Phone ______________________________

Have you had any previous surgery? No Yes If yes, please list:

Year _______________Hospital ______________________________Year _______________ Hospital _______________________________

Year _______________Hospital ______________________________Year _______________ Hospital _______________________________

Family History

Mother's Age_______State of Health _______________________Father's Age _______ State of Health _________________________

Brother's Age ______State of Health _______________________Sister's Age ________ State of Health _________________________

Child's Age ________State of Health _______________________Child's Age ________ State of Health _________________________

Child's Age ________State of Health _______________________Child's Age ________ State of Health _________________________

Personal History

TB Diabetes Epilepsy Heart Disease High Blood Pressure Asthma

Lung Disease Kidney Disease Mental Disease Cancer

Allergies____

Current Medications ____

____

PERTINENT PRE-OPERATIVE INFORMATION - CHECK ALL THAT APPLY

Have you ever reacted badly from a general anesthesia?

Do you have high blood pressure?

Do you bruise easily?

Have you taken steroids, cortisone, or ACTH?

Does your religion prohibit blood transfusions?

Have you ever had a bad reaction to local anesthetic?

Do you bleed unusually easy?

Have you ever required transfusions for surgery?

Do you have shortness of breath?

Are you pregnant?

Please Continue on Page 8

Palm Beach Breast Institute
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Breast History

Please fill out entire questionnaire

Name________________________ Date of Birth________________

Phone ________________________ Cell Phone ________________________

Date of Service ________________________ Send Results to Doctor ________________________

1. REASON FOR CURRENT EXAM *Check all that apply*

Routine		
Lump Felt	Right	Left
Discharge From Nipple	Right	Left
Pain	Right	Left
Skin Change	Right	Left
Nipple Retraction	Right	Left
Abnormality on Last Exam	Right	Left
Other	Right	Left

2. MENSTRUAL / PERIOD HISTORY

First Period Age ______
First Live Birth Age ______
Menopause Age ______
Hysterectomy Age ______
Ovaries Remove (One or Both) Age ______
Are you or could you be pregnant?
Did you Breast Feed?

3. BREAST CANCER HISTORY

Family History *Check all that apply*

Mother Age ______
Sister Age ______
Daughter Age ______
Grandmother Age ______
Male Relative/Other Age ______

Self History

Breast Cancer Age ______
Treatment: Chemo Tamoxifen
Radiation Other
Recurrence? Date________________

4. BREAST SURGERY HISTORY

Check all that apply

Breast Reduction	Right	Left
Biopsy Malignant	Right	Left
Lumpectomy	Right	Left
Mastectomy	Right	Left
Reconstruction	Right	Left
Implant (Augmentation)	Right	Left
Cyst Aspiration	Right	Left

5. DO YOU TAKE: *Check all that apply*

Hormones
Birth Control
Estrogen
Other________________________

6. PREVIOUS MAMMOGRAPHY? Yes No

When ________________________
Where________________________

7. PREVIOUS ULTRASOUND Yes No

When ________________________
Where ________________________

8. LAST PROFESSIONAL BREAST EXAMINATION

When ________________________
Where ________________________

9. DO YOU PERFORM SELF BREAST EXAMS? Yes No

Frequency ________________________

Please Continue on Page 9

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Financial Payment Policy

We find that communication with our patients regarding our financial policy assists us in providing the best possible care to you. Please take a moment to read this statement, sign and return it to the receptionist.

The doctor's services are provided directly to you and not to your insurance company. Therefore, you are responsible for payment of the services rendered.

As a courtesy to our patients, our office will bill your insurance company for you and not bill you directly until 45 days. If the insurance company has failed to pay within the 45 day period, we will expect you to pay the balance of your bill in full. You must then collect from your insurance company. Special needs are recognized by the office and it may be necessary to set up a payment plan for a patient requiring extensive treatment. If this situation is necessary for you, please bring this to the attention of someone in our billing office immediately at (561) 881-9100.

Thank you for taking the time to read this policy statement. We hope that if you have any questions concerning your bill that you will contact our billing department and that you will assist in the collection process by contacting your insurance company if necessary.

We are here to help!

I/We understand and agree that any credit granted shall be paid promptly in accordance with the terms and agreements, that the credit grantor may add one and one half percent (1½%) per month to any balance owed, and in event of default, to pay reasonable collection charges and/or attorney fees.

____
Patient Name

____ ________________
Signature Date

Thank you for your time!

PALM BEACH BREAST INSTITUTE, INC.
2151 45TH STREET, SUITE 208
WEST PALM BEACH, FLORIDA 33407
TELEPHONE: (561) 881-9100
PALMBEACHBREASTINSTITUTE.COM