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Suite 100  
Southampton, PA 18966

Dear \_\_\_\_\_,

Thank you for trusting your care to Comprehensive Breast Care Surgeons.

Your appointment is with \_\_\_\_\_ at our  
\_\_\_\_\_ office.

It is scheduled on \_\_\_\_\_ at \_\_\_\_\_

Please arrive 30 minutes prior to your appointment time if your paperwork is completed. If you need to complete the paperwork at the office, please arrive 45 minutes ahead of time. Please be aware that COPAYS ARE DUE AT THE TIME OF YOUR VISIT.

Please bring your x-ray films (i.e. mammogram, ultrasound, MRI, etc.) with written reports from the last two years with you to the office. If you've had an ultrasound and/or a breast MRI please be sure to request these films and reports as well. Please check to make sure the written reports are included with your films. These films and reports must be picked up by you at the facility where you had the studies performed and brought with you to the appointment. Most of these facilities require a 48 hour notice to have the films ready for you so please call and make arrangements in a timely fashion. If you have had a previous biopsy, please bring the pathology reports. If you do not have a copy of this report and it was performed within the last seven years, please request a copy from the doctor who performed the procedure.

Also, check with your insurance company to see if a referral from your primary care doctor is necessary. Should you need a referral, make sure that it is issued prior to your visit. Out of respect to all of our patients and the time that the doctor has scheduled to devote to each patient, we will have to reschedule you if the referral and/or films are not available at the time of your scheduled visit.

Please bring a list of ALL medications and dosages you are currently taking including over the counter drugs.

If you have any questions please feel free to call us 215-633-3456.

PLEASE USE BLACK INK ON ALL FORMS

**HOLY REDEEMER PHYSICIAN SERVICES**

**PATIENT INFORMATION PLEASE PRINT**

Patient Name: \_\_\_\_\_  
*First Middle Last Suffix*

Previous Name (if applicable): \_\_\_\_\_

Patient Date of Birth (DOB): \_\_\_\_\_  
*MM-DD-YYYY* \_

Soc. Sec. #: \_\_\_\_\_

Street: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Ext \_\_\_\_\_

Permission to leave message:

*(check all that are permitted)*

Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Patient declines to provide: \_\_\_\_\_

**Race:** *Check one that describes your race*

American Indian \_\_\_\_\_ Alaska Native \_\_\_\_\_ Asian \_\_\_\_\_ Black or African American \_\_\_\_\_

Native Hawaiian or Other Pacific Islander \_\_\_\_\_ Caucasian \_\_\_\_\_ Declines to provide \_\_\_\_\_

**Ethnicity:**

Hispanic or Latino \_\_\_\_\_ Not Hispanic or Latino \_\_\_\_\_ Declines to provide \_\_\_\_\_

**Language:**

English \_\_\_\_\_ Other, please provide \_\_\_\_\_ Declines to provide \_\_\_\_\_

Email Address: \_\_\_\_\_

I do not have an email address. If you have no email, please use [email@email.none](mailto:email@email.none)

**Primary Care Physician:**

Name of PCP: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Doctor who referred you: \_\_\_\_\_ (if applicable)

**Responsible Party: Self \_\_\_\_\_ OR**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

**Subscriber: Self \_\_\_\_\_ OR**

Name: \_\_\_\_\_

DOB: \_\_\_\_\_ SS: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Patient Employer: \_\_\_\_\_**

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Primary Insurance:**

Company: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

ID#: \_\_\_\_\_

Grp#: \_\_\_\_\_

**Secondary:**

Company: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

ID#: \_\_\_\_\_

Grp#: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Local Pharmacy:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Mail-In Pharmacy:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Note:** These items are for information being requested by the Government for reporting purposes.

I verify that my demographic information is correct by my signature below:

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Print Name: \_\_\_\_\_

Comprehensive Breast Care Surgeons

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Physician: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Reg#: \_\_\_\_\_

**Breast Risk Assessment**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Race: \_\_\_\_\_ DOB: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Menarche: \_\_\_\_\_ (Age at first menses) Age at birth of 1<sup>st</sup> child: \_\_\_\_\_

Number of Mothers/Sisters with Breast Cancer: \_\_\_\_\_

Number of previous breast biopsies: \_\_\_\_\_ Any atypical change on biopsy: Yes \_\_\_\_\_ No \_\_\_\_\_

Gail Risk Assessment: 5yr: \_\_\_\_\_ Lifetime: \_\_\_\_\_

# Pregnancies: \_\_\_\_\_ #Live Births: \_\_\_\_\_ #Miscarriages: \_\_\_\_\_

Last Menstrual Period: \_\_\_\_\_ Breast Fed: Yes \_\_\_\_\_ No \_\_\_\_\_

Birth Control Pills: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many years: \_\_\_\_\_

Hormone Replacement: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many years: \_\_\_\_\_

Fertility Meds: Yes \_\_\_\_\_ No \_\_\_\_\_ Are you of Ashkenazi Jewish decent: Yes \_\_\_\_\_ No \_\_\_\_\_

Current Medication: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Review of System

	Yes	No		Yes	No
1. Constitutional			7. Endocrine System		
• Weight Change	<input type="checkbox"/>	<input type="checkbox"/>	• Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
• Fevers	<input type="checkbox"/>	<input type="checkbox"/>	• Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
• Sweats	<input type="checkbox"/>	<input type="checkbox"/>	• Hormone Treatment	<input type="checkbox"/>	<input type="checkbox"/>
• Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	8. Breast/Genital		
2. Eyes			• Menopause	<input type="checkbox"/>	<input type="checkbox"/>
• Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	• Masses	<input type="checkbox"/>	<input type="checkbox"/>
• Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	• Genital Infections	<input type="checkbox"/>	<input type="checkbox"/>
• Vision Surgery	<input type="checkbox"/>	<input type="checkbox"/>	9. Urinary System		
3. Ear, Nose, Throat			• Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>
• Loss of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	• Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
• Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	• Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
• Nose Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	• Trouble Urinating	<input type="checkbox"/>	<input type="checkbox"/>
• Gum Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	10. Skin		
4. Respiratory			• Cancers	<input type="checkbox"/>	<input type="checkbox"/>
• Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	• Rashes	<input type="checkbox"/>	<input type="checkbox"/>
• Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	11. Neurologic		
• Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	• Stroke	<input type="checkbox"/>	<input type="checkbox"/>
• Asthma	<input type="checkbox"/>	<input type="checkbox"/>	• Seizures	<input type="checkbox"/>	<input type="checkbox"/>
• Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	• Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
5. Cardiovascular			• Nerve Damage	<input type="checkbox"/>	<input type="checkbox"/>
• Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	• Migraine	<input type="checkbox"/>	<input type="checkbox"/>
• Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	12. Psychiatric		
• Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	• Depression	<input type="checkbox"/>	<input type="checkbox"/>
• Anemia	<input type="checkbox"/>	<input type="checkbox"/>	• Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
• Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	• Other	<input type="checkbox"/>	<input type="checkbox"/>
• Phlebitis/Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	13. Musculoskeletal		
• High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	• Arthritis		
• High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	• Rheumatic Fever		
6. Gastrointestinal			• Osteoporosis		
• Reflux	<input type="checkbox"/>	<input type="checkbox"/>	14. Other _____		
• Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____		
• Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	_____		
• Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>			
• Constipation	<input type="checkbox"/>	<input type="checkbox"/>			
• Hernia	<input type="checkbox"/>	<input type="checkbox"/>			
• Gall Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>			
• IBS	<input type="checkbox"/>	<input type="checkbox"/>			

Have you ever been hit, hurt, or made to feel afraid by your intimate partner now or in the past? Yes \_\_\_\_\_ No \_\_\_\_\_

Review of systems cont.

I verify that my review of systems are correct by my signature below:

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_ DOB: \_\_\_\_\_

Physician: \_\_\_\_\_

Dear \_\_\_\_\_,

As you know, we strive to provide the highest level of care for all of our patients. Often, this comprehensive approach requires additional diagnostic or interventional treatment. Unfortunately, not all insurance companies recognize the need for these services to be provided in an office setting.

In order for us to provide this level of care in our office, patients may incur an out of pocket expense for those services not reimbursed by your insurance. In order to appropriately prepare you, we have enclosed a list of these services for your review. If you are at all uncomfortable with this or if it causes a financial burden, please be assured we will assist you in finding a treatment option that will help meet your needs.

Please be assured that we are in the process of educating the insurance carriers of this comprehensive approach to your care. We encourage you to make your insurance company aware of the financial difficulty that you have experienced receiving optimum care.

If you have any questions regarding this letter please contact me at (215) 633-3456 option 3.

Sincerely,

Kelly Smith Office  
Manager  
Comprehensive Breast Care Surgeons

COMPREHENSIVE BREAST CARE SURGEONS (A HOLY REDEEMER PHYSICIAN AND AMBULATORY SERVICES)

Patient Name: \_\_\_\_\_

Advance Beneficiary Notice (Please be advised that this document only applies to certain insurance companies. Please contact the billing office at 215-633-3456 opt 3 for more information.)

Please make a choice about receiving these healthcare services.

We expect that your insurance will not pay this office for the services listed below. They will not pay because your insurance has negotiated contracts for these types of procedures with specific vendors.

ESTIMATED CHARGES - THIS IS WHAT IT WILL COST IF YOU DECIDE TO RECEIVE THESE SERVICES FOR DATE OF SERVICE

BREAST ULTRASOUND - \$170.00  
FOLLOW-UP ULTRASOUND - \$140.00  
ULTRASOUND AXILLA - \$136.00  
ULTRASOUND AXILLA DEEP - \$39.00

PLEASE CHOOSE ONE OPTION - SIGN AND DATE BELOW

\*\*\* PAYMENT DUE AT TIME SERVICE IS RENDERED

OPTION 1 – YES, I WANT TO RECEIVE THESE SERVICES. I WILL PAY FOR THESE SERVICES AND WOULD LIKE THE CHARGES SUBMITTED TO MY INSURANCE. IF MY INSURANCE PAYS FOR THESE SERVICES YOU WILL REFUND ANY PAYMENTS I MADE TO YOU THAT ARE DUE ME.

OPTION 2 – NO, I HAVE DECIDED NOT TO RECEIVE THESE SERVICES. I UNDERSTAND THAT YOU WILL NOT SUBMIT A CLAIM TO MY INSURANCE AND THAT I WILL NOT BE ABLE TO APPEAL YOUR OPINION THAT MY INSURANCE WILL NOT PAY FOR THESE SERVICES.

DATE: \_\_\_\_\_

OPTION CHOSEN: \_\_\_\_\_

SIGNATURE OF PATIENT: \_\_\_\_\_

## Authorizations

### ALL PATIENTS

I authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or to carriers to my attorney or another physician's office. I hereby, authorize direct payment of medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, private insurance, and any other health plan to Holy Redeemer Physician Services and any of its affiliated practices.

I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing. I understand, that as these services were performed for me or my legal dependent, I am financially responsible for all charges whether or not paid by insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### MEDICARE PATIENTS

I request that payment for authorized Medicare/Medigap benefits be made to me or on my behalf to Holy Redeemer Physician Services and any of its affiliated practices for any services furnished to me by Holy Redeemer Physician Services and any of its affiliated practices. I authorize any holder of medical or other information about me to release any information needed by the Health Care Financing Administration and its agents in determining these benefits for related services.

Medicare Number: \_\_\_\_\_

1. Do you or your spouse work for a company that provides you with health insurance?  
Yes\_\_\_ No\_\_\_
2. Are you entitled to Medicare because of disability or End Stage Renal Disease?  
Yes\_\_\_ No\_\_\_
3. Is this illness or injury a result of an automobile accident or injury?  
Yes\_\_\_ No\_\_\_
4. Has treatment for the accident or illness been authorized by the Veteran Administration?  
Yes\_\_\_ No\_\_\_
5. Are you entitled to any benefits under the Federal Black Lung Program?  
Yes\_\_\_ No\_\_\_
6. I certify that this information is true and complete to the best of my knowledge.  
Yes\_\_\_ No\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

HOLY REDEEMER PHYSICIAN SERVICES  
CONSENT FOR FINANCIAL RESPONSIBILITY

Patient Name: \_\_\_\_\_

It has been explained to me and I understand that I will be financially responsible for any patient balance due under the following provisions:

Co-Pay Due/Deductible Not Met/Co-Insurance Due

I understand that I will be financially responsible for all co-pays due for services provided or if my deductible has not been met or if there is a co-insurance due.

Non-Covered Services

I agree to be responsible for any professional charges incurred for a non-covered service for which my health plan will not make payment. This includes breast ultrasounds performed in our office.

Enrollment Not in Effect/No Health Insurance

I understand that I will be financially responsible for all professional charges incurred if service was provided when my enrollment in a health plan was not in effect or if I have no health insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HOLY REDEEMER PHYSICIAN AND AMBULATORY SERVICES  
GENERAL CONSENT TO TREATMENT**

I hereby authorize Holy Redeemer Physician and Ambulatory Services, its physicians, nurse practitioners and staff to provide examinations, and/or evaluations, treatments, etc. as deemed necessary and in accordance with sound medical procedures. I hereby consent to such treatment and procedures with the understanding that treatment and procedures that involve significant risk will not be performed without my prior, specific informed consent.

I understand that as a part of the provision of my healthcare services by Holy Redeemer Physician and Ambulatory Services, health information is collected, compiled, and maintained in my medical record. This information includes a description of my health history, physical examinations, test results, surgical reports, pathology and other laboratory reports, medications, treatment plans, and communications among the healthcare staff.

I understand that this information is used as a source for my treatment and care, for preparation of my bill, for verification by my insurance carrier or third-party payer that services were billed correctly, and for routine healthcare operations of the facility such as conducting planning and auditing functions.

I acknowledge that I have received a copy of Holy Redeemer Physician and Ambulatory Services Notice of Privacy Practices that provides a more complete description of uses and disclosures of my health information and understand that I have the right to review this Notice prior to signing this consent.

I understand that I have the right to revoke this consent in writing except to the extent that Holy Redeemer Physician and Ambulatory Services has already taken action in reliance on the consent.

The undersigned certifies that he/she has read the above and is the patient, parent, guardian or representative authorized to execute the above and accept its terms.

\_\_\_\_\_  
Signature of Patient (or Person authorized to consent for Patient)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relationship to Patient of Person

\_\_\_\_\_  
Date

Effective 9/10/2015