Beth DuPree MD, FACS, ABIHM
Stacy Krisher MD, FACS, ABIHM
Catherine Carruthers MD, FACS, ABIHM

Please be sure to confirm the location of your appointment

45 2nd Street Pike Suite 100 Southampton, PA 18966	3300 Tillman Drive Bensalem, PA 19020	385 Oxford Valley Rd Suite 310 Yardley, PA 19067

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 service and we thank you for your cooperation.

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. 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 or breast surgery, 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. Also, make sure to bring your insurance card and a photo ID.

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

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:_____

Occupation:_____

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: _____ Patient ID#: _____

Reg #: _____ Physician: _____

Comprehensive Breast Care Surgeons

BREAST RISK ASSESSMENT

AGE: RACE: ALLERGIES:

MENARCHE: _____ (AGE OF FIRST PERIOD)

HOW OLD WERE YOU WHEN YOU HAD YOUR FIRST CHILD? _____

NUMBER OF MOTHER/SISITERS/DAUGHTERS WITH BREAST CANCER: _____

NUMBER OF PREVIOUS BREAST BIOPSIES: _____

ANY ATYPICAL/PRE-CANCEROUS CELLS ON BIOPSY? _____YES _____NO

GYNECOLOGICAL HISTORY: # PREGNANCIES: _____# LIVE BIRTHS: _____

 # MISCARRIAGES: ___

WHAT WAS THE FIRST DAY OF YOUR LAST MENSTRUAL PERIOD OR YOUR AGE AT MENOPAUSE? _____

WERE YOUR CHILDREN BREAST FED? _____YES _____NO

DID YOU USE BIRTH CONTROL PILLS? _____YES _____NO #YEARS _____

DO YOU USE OR HAVE USED HORMONE REPLACEMENT? _____ YES _____NO # YEARS_____

DO YOU USE OR HAVE YOU USED FERTILITY MEDS? _____ YES _____NO _____

ARE YOU OF ASHKENAZI JEWISH DESCENT? _____YES _____NO

DO YOU HAVE A LATEX ALLERGY? _____YES _____NO

MEDICATIONS- PLEASE LIST

_____

WHAT MEDICAL PROBLEMS ARE YOU TREATED FOR? _____

_____

DO YOU HAVE A PERSONAL HISTORY OF CANCER, IF YES WHAT TYPE

_____

HAVE YOU HAD PRIOR RADIATION THERAPY? _____

WHAT PRIOR SURGERIES HAVE YOU HAD? _____

DO YOU HAVE ANY FAMILY HISTORY OF CANCER (GRANDPARENTS, PARENTS, SIBLINGS, AUNTS, UNCLES, COUSINS)

RELATION	CANCER TYPE	AGE OF DIAGNOSIS
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name:_____ DOB:_____

Review of System

1. Constitutional

	Yes	No
• Weight Change	☐	☐
• Fevers	☐	☐
• Sweats	☐	☐
• Fatigue	☐	☐

2. Eyes

	Yes	No
• Glaucoma	☐	☐
• Cataracts	☐	☐
• Vision Surgery	☐	☐

3. Ear, Nose, Throat

	Yes	No
• Loss of Hearing	☐	☐
• Dizziness	☐	☐
• Nose Bleeding	☐	☐
• Gum Bleeding	☐	☐

4. Respiratory

	Yes	No
• Chronic Cough	☐	☐
• Bronchitis	☐	☐
• Shortness of breath	☐	☐
• Asthma	☐	☐
• Pneumonia	☐	☐

5. Cardiovascular

	Yes	No
• Heart Attack	☐	☐
• Chest Pain/Angina	☐	☐
• Heart Murmur	☐	☐
• Anemia	☐	☐
• Transfusions	☐	☐
• Phlebitis/Blood Clots	☐	☐
• High Blood Pressure	☐	☐
• High Cholesterol	☐	☐

6. Gastrointestinal

	Yes	No
• Reflux	☐	☐
• Hepatitis	☐	☐
• Blood in stool	☐	☐
• Diarrhea	☐	☐
• Constipation	☐	☐
• Hernia	☐	☐
• Gall Bladder Disease	☐	☐
• IBS	☐	☐

7. Endocrine System

	Yes	No
• Diabetes	☐	☐
• Thyroid Problems	☐	☐
• Hormone Treatment	☐	☐

8. Breast/Genital

	Yes	No
• Menopause	☐	☐
• Masses	☐	☐
• Genital Infections	☐	☐

9. Urinary System

	Yes	No
• Bladder Infections	☐	☐
• Kidney Stones	☐	☐
• Incontinence	☐	☐
• Trouble Urinating	☐	☐

10. Skin

	Yes	No
• Cancers	☐	☐
• Rashes	☐	☐

11. Neurologic

	Yes	No
• Stroke	☐	☐
• Seizures	☐	☐
• Head Injury	☐	☐
• Nerve Damage	☐	☐
• Migraine	☐	☐

12. Psychiatric

	Yes	No
• Depression	☐	☐
• Anxiety	☐	☐
• Other	☐	☐

13. Musculoskeletal
    - Arthritis
    - Rheumatic Fever
    - Osteoporosis
14. Other_____

_____

_____

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,

Deborah Kossovsky
Practice 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 Diease?
   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 RESPONSILBILITY

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, nurses, 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 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, complied, 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, auditing functions, and patient satisfaction.

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 2/2017

HOLY REDEEMER PHYSICIAN AND AMBULATORY SERVICES

STANDING CONSENT TO ACCESS EXTERNAL PRESCRIPTION HISTORY

PLEASE SIGN ONLY AFTER YOU HAVE READ AND UNDERSTAND ALL OF THE FOLLOWING

I, _____, whose signature appears below, authorize Holy Redeemer Physician and Ambulatory Services to obtain and use the external prescription history via the RxHub service for the patient listed below.

Please initial below. By initialing, you are agreeing to the respective terms and conditions set below and are fully agreeing to the terms above.

_____ I understand that prescribing history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be obtained and used by my Holy Redeemer Physician and Ambulatory Services provider and staff for treatment purposes , and it may include prescriptions issued back in time for several years.

_____ _____
Patient's Signature (Parent or Guardian if Patient is a Minor) Date

_____
If Guardian, Relationship to Patient

_____ _____
Witness of Signature (Practice Site Staff Member) Date

Permission to Speak to Another Individual Regarding Medical Care

Patient Name: _____ Date of Birth_____

Address:_____
_____

Names of people you would like us to speak with on your behalf with regards to your medical care:

Name:_____

Relationship: _____

Name: _____

Relationship: _____

Name:_____

Relationship: _____

_____ _____
Signature of Patient or Legal Guardian Date