Multi-Diagnostic Services, Inc.

139-16 91st Avenue
Jamaica, New York 11435
718 454-8556
Fax: 718 454-7950

Name:

Date of Appointment:_____

AM

Time:_____**PM**

What to Expect and How to Prepare for the Mammography Screening

What to Expect

It takes approximately 10 minutes to perform a mammography. Each breast is compressed twice. You will experience a "pinching" sensation during compression.

How to Prepare

1. Wear a two-piece outfit.
2. DO NOT USE ANY POWDER, DEODORANT, LOTION OR PERFUME in the breast or armpit area.

****WE WILL NOT PERFORM A SCREENING MAMMOGRAM IF YOU HAVE IMPLANTS OR HAVE STOPPED NURSING FOR LESS THAN 6 MONTHS.**

What to Bring

Bring two envelopes: one addressed to yourself with your home address and one addressed with your ob-gyn doctor's address. These will be the envelopes we will use to mail the reports. Also, bring your completed medical history form, a copy of the front and back of your insurance card with the insurance form to your appointment. DO NOT FAX THE FORM TO OUR OFFICE.

Please make every effort to obtain and bring your prior mammography films if you have not had a mammography with us in the past. They will be compared for subtle changes with your current films by our radiologist.

If your mammogram results indicate a need for additional testing, you will need to bring your films with you when you have the diagnostic follow up. We will send your original films to the diagnostic center or doctor you indicate. They will be sent by either "UPS" or "Federal Express" ground, receiving signature required." Please remit S10.00 to cover the cost of the mailing. Checks can be made payable to Multi-Diagnostics and mailed to the address shown above or payment can be made by American Express, Mastercard, Visa or Discover Card.

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Please Print Form must be filled out completely **Location of Screening**_____

Name _____ Date of Birth ___/___/_____ Age____ Date ____/____/____

Home Address _____ Apt# ____ City _____ State ___ Zip _____

Home Telephone# (___)_____ Work Phone# (___)_____ Social Sec# _____

PLEASE CIRCLE YOUR ANSWERS. PLEASE DO NOT LEAVE ANY UNANSWERED QUESTIONS

Past/Present Medications (If yes, state drug name and length of time used)

Birth Control Pills NO YES _____
Hormones NO YES _____
Thyroid NO YES _____

Age you began menstruating? _____
Number of pregnancies? _____
Your age at first pregnancy? _____
Date of last period? _____

Have you started Menopause: NO YES if yes: NATURAL SURGICAL Age Began _____
Have you had... A hysterectomy? NO YES if yes, at what age? _____ An Ovary Removed? NO YES (Left ,Right) Age? _____

Any Prior Breast Surgery?			When?	Which Breast?		Radiation Treatment?	
Mastectomy	NO	YES	_____	R L Both		NO	YES
Lumpectomy	NO	YES	_____	R L Both		NO	YES
Breast Biopsy	NO	YES	_____	R L Both		NO	YES
Drainage of Cyst	NO	YES	_____	R L Both		NO	YES
Breast Implants	NO	YES	_____	R L Both		NO	YES

Other _____

Do you have any of the following NOW?

Fibrocystic Disease	NO	YES	
Breast Lumps	NO	YES	R L Both
Tenderness	NO	YES	R L Both
Breast Pain	NO	YES	R L Both
Skin Retraction	NO	YES	R L Both
Nipple Discharge	NO	YES	R L Both

If yes, what color? _____

Are the above symptoms related to your period? NO YES SOMETIMES

Family History of Breast Cancer? (Please Circle)

Mother NO YES
Aunts NO YES Mother's or Father's side?
Sisters NO YES
Grandmothers NO YES Mother's or Father's side?
Daughters NO YES

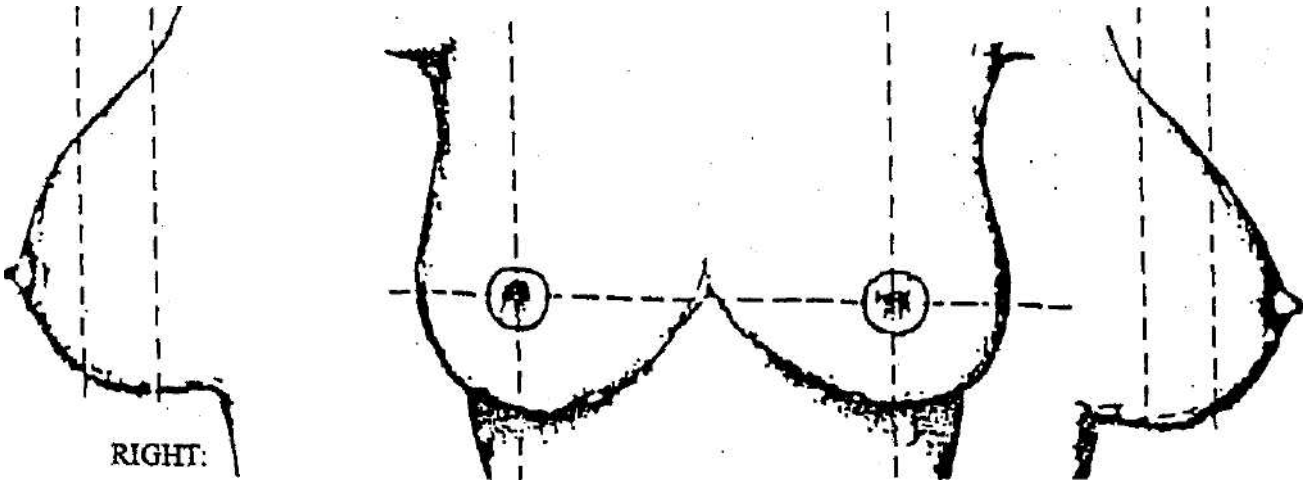
If Yes, at what age (approximately) was the person first diagnosed? _____

Previous Mammogram?

When? _____

Where? _____

Date of last Clinical Breast Exam? _____



OVER Technicians Signature _____

PLEASE READ AND SIGN ACKNOWLEDGING ITEMS 1-4

1.1_____ hereby give my consent and permission to Multi- Diagnostic Services. Inc., its technicians and employees, to perform a visual and/or manual breast examination and/or mammography test on me. I also understand that a visual and/or manual breast examination and/or mammography do not constitute a complete examination for cancer, nor do they guarantee the absence of cancer if the results are negative.

I am solely responsible for following any recommendations made to me by the physician for any subsequent follow-up examinations, diagnostic studies, evaluations or treatments in the event that the results of the examination or mammogram are suspicious for malignancy, or there is any area of questionable abnormality found.

2.1 HEREBY DECLARE THAT TO THE BEST OF MY KNOWLEDGE I AM NOT PREGNANT AT THIS TIME AND/OR THAT I AM NOT NURSING A CHILD.

3.1 authorize Multi-Diagnostic Services, Inc. to receive any and all medical records and reports that pertain to my mammography findings. This includes, but is not limited to: ultrasound; spot, magnification, and any other additional views; biopsy results as well as previous mammography and sono films. This will enable Multi-Diagnostic Services, Inc. to update my medical chart as per Mammography Quality Standard Act (MQSA/HR6182).

4.1 understand that the results of my examination and mammography will be reported to my designated physician. If follow-up test(s) are necessary, I give my permission for Multi-Diagnostic Services, Inc. to release rny mammography films to me, a person designated by me, a doctor or the facility doing the testing. If screened through the NY State DOH Breast Health Partnership Program your films will be sent to a participating partner facility for follow-up care and your medical/personal information will be released to the corresponding NY State Partnership office and the follow-up facility listed unless you tell us not to..
Your refusal must be in writing.
If desired; please provide us with the name of a relative or friend authorized to have your mammogram results along with their address and phone number:
Name _____Address/Phone

Signature _____ Date

Witness

Your Physician Information

Name _____ _____Phone Number

Address_____ Fax Number_____

_____Doctor's UPIN# (for medicare)_____
Medicaid Provider #

Medicare Patient

"1 request that payment of authorized Medicare benefits be made on my behalf to Multi-Diagnostic Services. Inc. for any services furnished to me by Multi-Diagnostic Services, Inc. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Beneficiary Signature _____ Date

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MULTI-DIAGNOSTIC INSURANCE INFORMATION SHEET
JOB:_____

PLEASE PRINT CLEARLY.

PATIENT NAME (AS IT APPEARS ON YOUR INSURANCE CARD)

_____

NAME OF INSURANCE CARRIER -

POLICY NUMBER/ PLAN TYPE (HMO / PPO)_____

HAVE YOU WAITED A YEAR SINCE YOUR LAST MAMMOGRAPHY? YES NO

ARE YOU THE PRIMARY POLICY HOLDER? YES NO

IF YOU CIRCLED NO ABOVE, PLEASE LIST PRIMARY POLICY HOLDER'S INFORMATION BELOW.

NAME _____

ADDRESS_____

DATE OF BIRTH_____ GENDER _____

DISCLAIMER

PLEASE MAKE SURE THIS IS YOUR CURRENT INSURANCE INFORMATION. PLEASE REVIEW FOR ACCURACY. WE WELL USE THIS INFORMATION TO BILL YOUR MAMMOGRAM. IF OUR CLAIM IS DENIED BY YOUR INSURANCE COMPANY FOR INCORRECT INFORMATION, YOU WILL BE RESPONSIBLE FOR THE PAYMENT OF THE MAMMOGRAPHY FEE.

SIGNATURE_____ DATE _____

Patient Privacy Notice Acknowledgment Form

The purpose of this form is to record acknowledgment of receipt of Privacy Notice, as required by the Health Information Portability and Accountability Act of 1996 (HIPAA). Should such acknowledgment be unobtainable, this form will document the company's good faith attempt to acquire such acknowledgment.

Part A: I _____ **acknowledge receipt of the University Physicians**
{insert patient's name} **Group Privacy Notice and Practices.**

Signed:_____ **Date:** _____

Part B: MULTI-DI AGNOSTIC SERVICES, INCORPORATED, made a good faith

attempt to obtain _____
(insert patient's name)
acknowledgment of receipt of Privacy Notice, but was unable to do so for the following rcason(s);

☐ **Individual refused to sign** ☐ **An emergency situation prevented us from obtaining it**

☐ **Communications barriers prohibited obtaining it** ☐ **Other (please specify)** _____

Signed:_____ **Position:** _____ **;** _____ **Date:**
(Employee)

Part C: The first treatment encounter of the office with._____**was by**
{insert patient's name}
telephone on _____, **and a copy of the Notice of Privacy Practices of the office and a copy**
(insert date of phone call)

of this Acknowledgement Form were mailed to the patient on such date, with a request to the patient to return to the office the completed

Part A of this form.

Signed:_____ _____ Position:_____ Date:_____
(Employee)

The completed form is to be placed in the patient's medical record

INSURANCE RECEIPT

Multi-Diagnostic Services, Inc.
139-16 91 Ave
Jamaica. NY 11435
Tax ID# 11-2879834

PLACE OF SERVICE:

Date of Service:
Patient Name
Patient's Address

Telephone ( )_

DOB

Insured's Name _____
(if different from patients name)

Insured's Address _____

_____

Insurance ID# _____

Group / Plan# _____

Total Charge: _____ Total Paid: _____

MAMMOGRAPHIC EXAMINATION

CPT CODE	FEE
77055 Unilateral Mammography	
77056 Diagnostic Mammography	
77057 Screening Mammography- Bilateral	
77052 CAD- Computer Aided Detection	

Co-Pay _____

DIAGNOSIS ICD.9.CM (CIRCLE)

611.72 Lump or mass in breast
611.9 Unspecified disorders of breast
V76.12 Breast screening, unspecified
V76.11 Screening mammogram for high-risk patient

Balance Due: _____