REGISTRATION INFORMATION

PATIENT INFORMATION (Please Print Clearly)

FIRST NAME: ____________________MI:______LAST NAME :_________________

ADDRESS:____

CITY: _____________________________ STATE: ______ ZIP CODE: _____________

PRIMARY PHONE: _________________ SECONDARY PHONE: ________________

SOCIAL SECURITY #: __________________ SEX: M/F DATE OF BIRTH: ________

EMPLOYER NAME: ____

ADDRESS: ____

EMPLOYER PHONE #: _________________________

EMAIL ADDRESS: ____

IN CASE OF EMERGENCY, CONTACT:
____________________________________ RELATIONSHIP: ____________________
HOME PHONE: ____________________ CELL PHONE: ________________________

INSURANCE INFORMATION: DO YOU HAVE HEALTH INSURANCE? YES/NO
PRIMARY INSURANCE CARRIER

INSURANCE COMPANY: ____

POLICY #: _________________________________ GROUP #: ___________________

NAME & DATE OF BIRTH OF INSURED: ___________________________________

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY: ____

POLICY #: _________________________________ GROUP #: ___________________

NAME & DATE OF BIRTH OF INSURED: ___________________________________

Full Name: ____ DOB: __________________

TREATMENT AUTHORIZATION

I HEREBY AUTHORIZE DR. APRIL JOHNSON MADDUX TO UNDERTAKE EVALUATION AND TREATMENTS OF THE VARIOUS CONDITIONS FOR WHICH I PRESENT MYSELF.

SIGNATURE OF PATIENT

____DATE:___________
(PATIENT or LEGAL guardian's signature if patient is a minor)

PAYMENT AUTHORIZATION

I hereby authorize the Breast Care Center of Birmingham to furnish medical information concerning my visits to my insurance company. I direct the insurer to pay, directly to the physician, all benefits due her as a result of these claims. I am aware that I am personally responsible for all charges. If such charges are left unpaid after multiple billings have been made, and if at that time, the physician should then determine that it is appropriate the account be forwarded to a collection agency or an attorney, or for any court costs and reasonable attorney fee involved in collection of any amounts due from me.

SIGNATURE OF PATIENT:

____DATE:____________
(PATIENT or LEGAL guardian's signature if patient is a minor)

Full Name: _______________________________________ DOB: ________________

Welcome to the Breast Care Center of Birmingham, we are here to serve you. If you should have any questions or concerns while you are here please address your issues with our office manager.

All co-payments, as well as outstanding patient balances are due at the time services are rendered.

If it is required your insurance referral must be in the office at the time of your visit or your appointment will be rescheduled.

Routine prescriptions will not be called in after hours or on weekends. Please call ahead to have your refills called into your Pharmacy.

$15.00 charge for all short term disability and FMLA forms.

ATTENTION

There will be a $50.00 fee charged for any appointment not kept canceled or rescheduled within a 24 hour notice.

There will be a $100.00 fee charged for any surgery not kept, canceled, or rescheduled within a 48 hour notice.

At all appointments update any information changes

By signing this form I acknowledge Breast Care Center of Birmingham policy and procedures.

Patient Signature

____ Date ________________

***If you would like a copy of this form for your records please request at the time of your visit.**

Full Name: ____ DOB: __________________

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, I acknowledge that I have received a copy of the Breast Care Center of Birmingham's Notice of Privacy Practices.

DATE: ___________________________

________________________________ Chart Number

________________________________ Date of Birth

________________________________ Patient Name

________________________________ Signature of Patient

________________________________ Name of Patient Representative (if applicable)

If signing as a personal Representative, describe authority to act for patient and submit documentation showing authority:

____

________________________________ Witness (signature of office staff)

For Staff Only

Reason Privacy Notice Acknowledgement Not Obtained:

- o Patient was provided notice but refused to sign acknowledgement
- o Patient not present (obtain when present)
- o Patient indicated they had already received and/or signed acknowledgement
- o Emergency situation (patient unable to sign acknowledgement due to emergency)
  - o Notice was provided to patient as soon as reasonably possible after emergency situation, OR
  - o Notice was provided to patient as soon as reasonably possible after emergency, but the patient refused to sign acknowledgement

Full Name: ____ DOB: __________________

Main Reason For Visit (please check only one):

____ To have a mammogram ____ Abnormal mammogram ____Breast pain

____ Breast lump _____ Other ____

Breast pain, lump, or "other" first found by: ____ Me _____ Dr ____ Mammogram

Are You Currently Having Any of the Following Problems?:

1. Lumps in the breast: ____ No _____Yes - ____Right _____Left _____Bilateral
   Since when- _____________ how did you find the lump: ___________________
2. Nipple Discharge: ____ No _____Yes - ____Right _____Left _____Bilateral
   Since when- ___________
   Method of detection: _____ Spontaneous ____ Expressed
   Color: ____ Brown ____ Green ____ Red ____Clear _____White _________Other color
3. Breast tenderness or Pain: ____ No _____Yes - ____Right _____Left _____Bilateral
   Since when - _________________
   My breast pain is: ____Continuous ____Off and on
4. Breast redness or swelling: ____ No _____Yes - ____Right _____Left _____Bilateral
   Since when - _______________________
5. Prior breast injury: _____ No _____Yes
6. Other complaints:
   ____
   ____

Mammography Information

If you are having a mammography today, is it for a routine checkup?____Yes ___No
Have you had a previous mammogram? _____Yes _____No
If yes, where was your last mammogram? ___________________________________
When: ______/_______/_______
Do you practice monthly breast self-exams? _____Yes _____No _____Sometimes

Full Name: ____ DOB: __________________

Ob/Gyn History

1. Have you had a hysterectomy? ____Yes ____No Date of surgery: ___/___/____
   Have your ovaries been removed? _____No _____One _____Both _____Unsure
2. Date of most recent pelvic exam: _____/_____/______

Are you pregnant? _____Unsure _____No _____Yes Due Date ____/_____/____

3. Age of first menstrual cycle: ___________
4. Are you still having periods? _____Yes _____No
5. Beginning date of last menstrual cycle: _____/______/______
6. Which option best describes you:
   _____Have not had menopause yet _____Currently undergoing menopause
   _____Not sure if I have undergone menopause _____Already underwent menopause
   Age when you underwent menopause _______
   Type of menopause: _____Natural- stopped itself
   _____Surgical-ovaries/uterus removed
7. Number of pregnancies: _________
8. Age at first birth: _________
9. Did you ever breast feed? _____Yes _____No
   Age at first breast feeding: ______ How long?(All the children together)______ Months

Hormonal Medical History:

1. Birth control pills:
   ____Never used ____Off and on use ____One long continuous period of use
   Age started _____ Total years used______

Currently taking birth control pills? _____Yes ____No

2. Hormone replacement therapy:
   ____Never used _____Off and on use _____One long continuous period of use
   Age started ______ Total years used ______

3. Infertility drugs/hormones:
   _____Never used _____Off and on use _____One long continuous period of use
   Age started _____ Age stopped _____ Total months used ______

Breast Surgery/Treatment History:

1. Have you ever had a breast cyst(s)? _____Right _____Left _____Both
   ____No (cysts are little sacs of fluid that are sometimes drained with a needle or maybe seen on mammogram/ultrasound)
2. Number of needle biopsies you have had: _____(done in office or breast imaging area)

If you have had a biopsy(s), which breast(s)? ____Right ____Left ____Both
Type of needle biopsy: ____ FNA ____Core _____ Unsure

Full Name: ____ DOB: __________________

3. Number of surgical biopsies you have had: ____(These involve cutting into the breast skin and are usually done in the operating room)

If you have had a biopsy(s), which breast(s) _____Right _____Left _____Both
Did the pathology show ADH (atypical ductical hyperplasia) ____Yes ____No _____Not Sure
Did the pathology show LCIS (Lobular Carcinoma in situ) ____Yes ____No ____Not Sure
Age when you were first diagnosed with LCIS: ______

4. Have you ever been diagnosed with breast cancer? ____Yes _____No

If yes, which breast(s) had cancer? _____Right _____Left _____Both
What type of surgery have you had for breast cancer?
_____Removal of part of the breast
_____Removal of the whole breast

5. Have you ever had breast implants? ____Yes _____No

If yes, do you currently have implants? _____Yes _____No
Have you ever had silicone implants? _____Yes _____No
Any trouble with leaking implants? _____Yes _____No

<u>Your Health History:</u>

1. Height: ____feet _____ inches Weight: ______pounds
2. Do you have a history of cancer other than breast cancer? ____Yes ____No
3. Have you ever had radiation therapy? ____Yes ____No
4. Have you ever had chemotherapy? ____Yes ____No
5. Do you have rheumatoid arthritis,lupus,Raynaud's or scleroderma? __Yes __No
6. Have you ever tested positive for AIDS or HIV? ____Yes ____No
7. Have you ever had general anesthesia? ____Yes ____No ____Unsure
   If yes, were there any problems? ____Yes ____No
   Do you have any family history of anesthesia problems? ____Yes ____No
8. Do you have any bleeding problems? ____Yes ____No
   Are you taking any blood thinners? ____Yes ____No
   Are you on daily aspirin? ____Yes _____No
9. Marital status: ____Single ____Married _____Divorced _____Widow
10. Highest level of education: _____ High school _____ Some college
    _____ College degree
11. Current employment status: _____Employed _____ Retired _____Disabled
    _____Unemployed
    Occupation: ____
    Occupational toxin history: ____

12. Caffeine Use: List by regular use cups/glasses per day, week or month
Coffee _____/_____Tea _____/_____Cola _____/_____ Chocolate bar_____/_____

Full Name: ____ DOB: ________________

13. Alcohol use: ____Yes _____No
    If yes, how many drinks per week? _____Beer_____Wine_____Hard liquor____
14. Tobacco use (ever): ____Yes ____No ____Yes, sporadic
    Type: ____Cigarette ____Cigar ____Pipe ____Snuff ____Previous smoker
    For cigarette smokers: _____packs per day for ______ years
15. Have you ever taken street/recreational drugs? _____Yes _____No
    If yes, please specify: ____

Current medications and doses:

____
____
____
____

Drug or Food allergies and reactions:

____
____
____
____

List previous surgeries and dates:

____
____
____
____

List any medical problems and when they were diagnosed:

____
____
____
____

Full Name: ____ DOB: __________________

Family History:

Please list all realtives including yourself, sons,daughters, mother, father, sisters, brothers, maternal and paternal aunts and uncles, and grandparents. Please include any major medical problems and if they were diagnosed with cancer their age at that time. Circle "L" for living and "D" for deceased and the current age if living or the age at death if deceased. If you are adopted include your family members that are genetically related to you.

Relationship	L/D	AGE	Major Medical Problems	Type of cancer & age @ Diagnosis
Self	L/D			
Daughter/Son	L/D			
Daughter/Son	L/D			
Daughter/Son	L/D			
Daughter/Son	L/D			
Mother	L/D			
Father	L/D			
Sister/Brother	L/D			
Sister/Brother	L/D			
Sister/Brother	L/D			
Maternal Grandmother	L/D			
Maternal Grandfather	L/D			
Maternal Aunt/Uncle	L/D			
Maternal Aunt/Uncle	L/D			
Maternal Aunt/Uncle	L/D			
Paternal Grandmother	L/D			
Paternal Grandfather	L/D			
Paternal Aunt/Uncle	L/D			
Paternal Aunt/Uncle	L/D			
Paternal Aunt/Uncle	L/D			

Full Name: ____ DOB: ____________________

Questionnaire

Instructions: Please circle **Y** to those that apply to you OR your family.

HEREDITARY BREAST AND OVARIAN CANCER (BRCA1 AND BRCA2 genes)

Y N - Breast cancer before age 50

Y N - Ovarian cancer at any age

Y N - Bilateral breast cancer at any age

Y N - Bilateral breast cancer and ovarian cancer at any age

Y N - Male breast cancer at any age

Y N - Ashkenazi Jewish ancestry with breast or ovarian cancer at any age

HEREDITARY MELANOMA [p16 (CDKN2A) gene]

Y N - ≥ 2 Melanomas

Y N - ≥ 2 Individuals in the same family with melanoma

Y N - Melanoma and pancreatic cancer in the same individual or family

HEREDITARY NONPOLYPOSIS COLORECTAL CANCER (MLH1, MSH2, and MSH6)

Y N - Colorectal cancer before age 50

Y N - Endometrial cancer before age 50

Y N - Colorectal cancer after age 50 and a family member diagnosed with any of those cancers* (see below and please circle those that apply)

*Cancers: colorectal, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenoma

FAMILIAL ADENOMATOUS POYPOSIS (APC and MYH genes)

Y N - ≥ 100 colon polyps

ATTENUATED FAMILIAL ADENOMATOUS POLYPOSIS (APC and MYH genes)

Y N - ≥ 10 cumulative polyps

Full Name: ____ DOB: ___________________

Breast Care Center of Birmingham

NOTICE OF HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE.
This notice describes the health information practices at Breast Care Center of Birmingham. This covered site, and location follows the terms of this notice.

OUR PLEDGE REGARDING MEDIAL INFORMATION:
We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at Breast Care Center of Birmingham. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Breast Care Center of Birmingham, whether made by hospital/clinic personnel or your personal doctor. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; comply with the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.
The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment and Treatment Alternatives. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical residents or students, or other Breast Care Center other then the Breast Care Center of Birmingham may share medical information about you in an attempt to coordinate the different things you need, such as prescriptions, lab work and x-rays. We may disclose medical information about you to people outside Breast Care Center of Birmingham who may be involved in you medical care after you leave, such as your local physician, family members, clergy or others we use to provide services that are part of your care. We may use and disclose your medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive through Breast Care Center of Birmingham may be billed to and payment may be collected from you, and insurance company or a third party. For example, we may need to give your health plan information about surgery you received at Breast Care Center of Birmingham so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

Full Name: ____ DOB: __________________

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.
Although all records concerning your hospitalization and treatment obtained at Breast Care Center of Birmingham are the property of Breast Care Center of Birmingham, you have the following rights regarding medical information we obtain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Breast Care Center of Birmingham. If you request a copy of the information, a reasonable fee for the costs of copying, mailing or other supplies designated with your request, may be charged.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another physician chosen by Breast Care Center of Birmingham will review your request and the denial. The person conducting the review will not be the person who denied the request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request amendment for as long as the information is kept by or for Breast Care Center of Birmingham. To request an amendment, your request must be made in writing and submitted to the medical records department at Breast Care Center of Birmingham. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for Breast Care Center of Birmingham;
- Is not part of the information which you would be permitted to inspect or copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an “accounting of disclosures.” This is a list of certain disclosures we made of medical information about you.

To request this list or accounting disclosures, you must submit your request in writing to Breast Care Center of Birmingham. Your request must stat e a time period which may not be longer then six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Full Name: ____ DOB: __________________

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care employer if the employer requires the healthcare services to determine whether you suffered a work-related injury.
Food and Drug Administration (FDA). We may disclose to the FDA and to manufacturers health information relative to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.
Victims of Abuse, Neglect or Domestic Violence. We are required to report child, elder and domestic abuse or neglect to the State of Alabama.
Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Lawsuits and Disputes. If you are involved In a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested. We may disclose medical information for judicial or administrative proceedings, as required by law.
Law Enforcement. We may release medical information for law enforcement purposes as requested by law, in response to a valid subpoena, for identification and location of fugitives, or missing persons, for suspected victims of crime, for deaths that may have resulted from criminal conduct and for suspected crimes on the premises.
Coroners, Medical Examiners, and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.
Organ and Tissue Donations. If you are an organ donor, we may use or release medical information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation off organ, eye or tissue to facilitate organ or tissue donation and transportation.
To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
National Security and Intelligence Activities. We may disclose medical information about you to authority federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
Workers Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.
Other uses and disclosures. Any other uses and disclosures will be made only with your written authorization.

Full Name: ____ DOB: __________________

You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not disclose information about a illness you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the medical records department of Brest Care Center of Birmingham. In your request, you must tell us (1)what information you want to limit; (2) whether you want to limit our use, disclosure or both; and to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Breast Care Center of Birmingham. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice. You may ask us to give you a copy of this notice at any time. Even if you agreed to receive this electronically, you are entitled to a paper copy. To obtain a paper copy of this notice, simply request one a Breast Care Center of Birmingham.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice of Privacy at Breast Care Center of Birmingham facility. The notice will contain on the first page, in the upper right hand corner, the effective date. In addition, each time you visit Breast Care Center of Birmingham to receive services, we will have available to you a copy of the current notice in the office.

FOR MORE INFORMATION OR TO REPORT A PROBLEM
If you have questions and would like additional information or feel like your privacy rights have been violated you may contact.

April Johnson Maddux, MD
Breast Care Center of Birmingham
Professional Building, Suite 207
2018 Brookwood Medical Center Drive
Birmingham, AL 35209
(205)877-2987

Full Name: ____ DOB: ___________________