Texas Breast Specialists

PATIENT NAME:____ DATE OF BIRTH:___________________

REASON FOR CONSULTATION:____

____

BREAST REVIEW OF SYSTEMS: PLEASE CHECK THE SYMPTOMS YOU ARE EXPERIENCING.

GENERAL:
____chills
____fatigue
____fever
____night sweats
____weight gain > 10 lbs
____weight loss > 10 lbs

SKIN:
____bruising
____rash
____color changes

HEENT:
____headache
____blurred vision

NECK:
____mass or lump
____swollen glands

RESPIRATORY:
____chronic cough
____difficulty breathing

CARDIOVASCULAR:
____chest pain
____irregular heart beat
____rapid heart rate
____shortness of breath
____swelling of extremities

GASTROINTESTINAL:
____abdominal pain
____black tarry stools
____bloody stools
____change in bowel habits
____constipation
____diarrhea
____nausea and vomiting

FEMALE GU:
____abnormal vaginal bleeding
____menstrual irregularities
____pelvic pain
____urinary complaints
____vaginal discharge

MUSCULOSKELETAL:
____muscle pain
____bone pain

NEUROLOGIC:
____headaches
____numbness and weakness

PSYCHIATRIC:
____anxiety
____depression
____insomnia
____panic attacks
____suicidal ideation

ENDOCRINE::
____cold intolerance
____hair changes
____heat intolerance
____hot flashes
____libido changes

HEMATOLOGY:
____abnormal bleeding
____anemia
____easy bruising
____enlarged lymph nodes
____nose bleeds
____prolonged bleeding

MALE GU:
____lump in testicle
____penile discharge
____prostate conditions

OTHER SIGNIFICANT SYMPTOMS NOT LISTED

____

____

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____

Texas Breast Specialists

PATIENT NAME____ DATE OF BIRTH_____________________

PHYSICANS:

Referring Physician__________________________________

Primary care Physician________________________________

Gynecologist____

Other physicians you wish us to update

____

ALLERGIES (please list your reaction to each medication)

____

____

____

____

FAMILY HISTORY: list family member and age at diagnosis

Breast Cancer______________________________________

____

____

Ovarian Cancer_____________________________________

____

Other cancers______________________________________

____

____

MEDICATIONS: list all vitamins, supplements and over the counter medications with dosage

____

____

____

____

____

____

____

____

____

____

Will you allow Texas Breast Specialists to obtain your medication history electronically from your pharmacy?

YES NO

PHARMACY:

NAME:____

PHONE NUMBER:______________________________

CROSS STREETS:______________________________

____

Other significant family history____

____

SOCIAL HISTORY: Indicate how many times per day or week

____Caffeine_______________________________________ ____Alcohol_______________________________________

____Tobacco_______________________________________ ____Illicit drugs____________________________________

I certify that the information I have provided is correct. I will not hold my doctor or members of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature:____Todays date_____________________________

Texas Breast Specialists

PATIENT NAME____DATE OF BIRTH_______________________

ADDITIONAL HISTORY

BRA SIZE ______________________________________

LAST MENSTRUAL PERIOD______________________

AGE AT FIRST PERIOD__________________________

DATE OF LAST PAP SMEAR______________________

METHOD OF CONTRACEPTION__________________

ARE YOU PREGNANT? YES NO

ARE YOU BREAST FEEDING YES NO

AGE AT FIRST PREGNANCY_____________________

AGE AT FIRST LIVE BIRTH______________________

AGE AT MENOPAUSE_____________________________

HISTORY OF HORMONE REPLACEMENT THERAPY

YES NO

PAST SURGICAL HISTORY

____appendectomy
____back surgery
____breast biopsy
____cataracts
____C-section
____Colon surgery
____detached retina
____Gallbladder surgery
____Heart surgery
____Hemorrhoid surgery
____Hysterectomy
____Inguinal hernia
____Lumpectomy
____Mastectomy
____Ovary removal
____Prostate surgery
____Stomach resection
____Splenectomy
____Thyroidectomy
____Tonsillectomy
____Umbilical hernia

OTHER SURGERIES

____

____

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OTHER MEDICAL CONDITIONS AND DIAGNOSISES

____Anesthesia complications
____Arthritis
____Asthma
____Atrial fibrillation
____Bleeding disorder
____Chest pain
____Congestive heart failure
____Chronic lung disease (COPD)
____Diabetes mellitus
____Emphysema
____History of blood clots
____Heart disease
____Hepatitis
____Herpes
____High blood pressure
____History of cancer ______________________________
____HIV positive
____Hyperthyroidism (high)
____hypothyroidism (low)
____Pacemaker
____Past heart attack
____Seizures
____Sickle cell anemia
____STD (sexually transmitted disease)
____Stroke
____Transient ischemic attack (TIA)
____Tuberculosis
____OTHER

____

____

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____

Assignment of Benefits and Financial Responsibilities

Patient Name:____ ____________ ______
Last First M.I. Date of Birth Age

Home Phone: (   ) ____________ Cell: (   ) ____________ Work: (   ) ____________

Home Address:____
Street City State Zip Code

Mailing Address:____
Street City State Zip Code

Email Address:____

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Home Health / Hospice (Name):____

The Texas Cancer Incident Reporting Act requires cancer incidence reporting to the Texas Cancer Registry (TCR) mandatory. Primary racial origin captures information used in research and cancer control activities.

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian/Indian/Pakistani/Sri Lankan ☐ Chamorran ☐ Chinese ☐ Fiji Islander ☐ Filipino ☐ Guananian NOS ☐ Hawaiian ☐ Hmong ☐ Japanese ☐ Kampuchean/Cambodian ☐ Korean ☐ Laotian ☐ Melanesian NOS ☐ Micronesian NOS ☐ Native American ☐ New Guinean ☐ Other Asian including Asian NOS and Oriental NOS ☐ Pacific Islander NOS ☐ Polynesian NOS ☐ Samoan ☐ Tahitian ☐ Thai ☐ Tongan ☐ Vietnamese ☐ Other

Employer:____
Name Address City State Zip

Responsible Party:______________________ ____________ (   ) ________
Name Relationship Telephone

Emergency Contact
Spouse/Next of Kin:______________________ ____________ (   ) ________
Name Relationship Telephone

Alternate Emergency Contact:______________________ ____________ (   ) ________
Name Relationship Telephone

Referring Physician: Primary Care Physician:

Primary Insurance:______________________ Telephone: (   ) ________

Subscribers Name:____________ DO B:____________ Employer: ____________

Policy Number: Group Number:

Secondary Insurance:______________________ Telephone: (   ) ________

Subscribers Name:____________ DO B:____________ Employer: ____________

Policy Number: Group Number:

Tertiary Insurance:______________________ Telephone: (   ) ________

Subscribers Name:____________ DO B:____________ Employer: ____________

Policy Number: Group Number:

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection, and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Texas Oncology P.A.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Texas Oncology P.A. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Texas Oncology P.A.
4. I understand that I have the right to request and receive a Notice of Privacy Practices from Texas Oncology P.A.

Notice to Patients: By submitting your check for payment, you are authorizing Texas Oncology, PA, or its agent, upon receipt of your check to convert the check to an electronic payment item or draft and to submit it for payment as an ACH debit entry or draft to your account, in accordance with the same terms and conditions as your check.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

______________________________ ______________________
Patient Signature Date/Time AM or PM (*circle one*)

______________________________ ______________________
Responsible Party Signature Relationship Date/Time AM or PM (*circle one*)

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Patient Name: ______________________ **Account #**____________

Please Print TXO will Complete

Why are we asking these questions? In 2009 Congress passed the HITECH Act to create uniformity among electronic health records. Asking for your language ensures you and your healthcare providers will be able to communicate clearly. We will be asking about race & ethnicity because some groups are at a higher risk of developing certain diseases. This information will be updated in your medical record and will remain confidential.

Circle Preferred Language

AMERICAN SIGN LANGUAGE	FRENCH CANADIAN	LAO	SWAHILI
ARABIC	GERMAN	MAORI	SWEDISH
ARMENIAN	GREEK	MIEN	TAGALOG
BRAZILIAN PORTUGUESE	GUJARATI	NAVAJO	THAI
CHINESE	HEBREW	NORWEGIAN	TIGRINYA
CHINESE (CANTON)	HINDI	OROMO	TURKISH
CHINESE MANDARIN	HMONG	OTHER	UNDEFINED
CROATIAN	HUNGARIAN	PERSIAN	URDU
DANISH	INDIAN	POLISH	VIETNAMESE
ENGLISH	INDONESIAN	PORTUGUESE	VISAYAN
FARSI	ITALIAN	RUSSIAN	YIDDISH
FILIPINO	JAPANESE	SLOVAK	
FINNISH	KHMER	SOMALI	
FRENCH	KOREAN	SPANISH	

Circle Ethnicity HISPANIC OR LATINO NOT HISPANIC OR LATINO

Circle Preferred Method of Contact **H**ome phone **C**ell phone **W**ork phone Email Mail Home Address

Phone number not previous provided ____________________ H C W (circle type)

Email address: _______________________________________

CIRCLE RACE

AFRICAN AMERICAN	HMONG	OTHER ASIAN INCLUDING ASIAN NOS AND ORIENTAL NOS
ASIAN INDIAN PAKISTANI SRI LANKAN	JAPANESE	PACIFIC ISLANDER NOS
CAUCASIAN	KAMPUCHEAN CAMBODIAN	POLYNESIAN NOS
CHAMORRAN	KOREAN	SAMOAN
CHINESE	LAOTIAN	TAHITIAN
FIJI ISLANDER	MELANESIAN NOS	THAI
FILIPINO	MICRONESIAN NOS	TONGAN
GUAMANIAN NOS	NATIVE AMERICAN	VIETNAMESE
HAWAIIAN	NEW GUINEAN	UNKNOWN
HISPANIC	OTHER ASIAN INCLUDING ASIAN NOS AND ORIENTAL NOS	OTHER

Options/Values were selected by HITECH Act and Texas State Tumor Registry.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Texas Breast Surgeons is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. **Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.**

I acknowledge that I have received a copy of the Notice of Privacy Practices of Texas Oncology.

Name: ______________________________________

Signature: ______________________________________

Name of Personal Representative (if appropriate):

____

Signature of Personal Representative (if appropriate):

____

Date: ____

Texas Breast Surgeons______________________________
Date acknowledgement received: _________________________

-OR-

Reason acknowledgement was not obtained:
____
____
____

4716 Alliance Blvd., Suite 180
Plano, TX 75093
Phone 972 596-8383

8080 State Highway 121, Suite 210
McKinney, TX 75070
Phone: 972 562-5999

EXAS B REAST S URGEONS

NOTICE OF PR IVACY PRA CTIC ES

Effective Date: April 14, 2003

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

About Us

In this Notice, we use terms like "we," "us" or "our" to refer to Texas Oncology its physicians, employees, staff and other personnel. All of the sites and locations of Texas Oncology follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes as described in this Notice.

Purpose of this Notice

This Notice describes how we may use and disclose your health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities

We are required by law to maintain the privacy of your health information and provide you notice of our legal duties and privacy practices with respect to your health information. We will abide by the terms of this Notice.

How We May Use or Disclose Your Health Information

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use your health information to provide you with medical treatment or services. For example, your health information will be disclosed to the oncology nurses who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your physician or another healthcare provider to be sure those parties have all the information necessary to diagnose and treat you.

For Payment : We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

We may share your health information with pharmaceutical company patient assistance programs and patient support organizations in order to assist you in obtaining payment for your care or payment for certain parts of your care.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities.

We may ask you to sign your name to a sign-in sheet at the registration desk and we may call your name in the waiting room when we call you for your appointment.

We may disclose your health information to a third party that performs services, such as billing and collection, on our behalf. In these cases, we will enter into a written agreement with the third party to ensure they protect the privacy of your health information.

Appointment Reminders: We may use and disclose your health information in order to contact you and remind you of an upcoming appointment for treatment or health care services.

Individuals Involved in Your Care or Payment for Your Care: We may release your health information, including information about your condition, to a family member or friend who is involved in your medical care or who helps pay for your care. **If you would like us to refrain from releasing your health information to a family member or friend, please notify the Medical Records Department.** We may also disclose your health information to disaster-relief organizations so that your family can be notified about your condition, status and location.

We are also allowed by law to use and disclose your health information without your authorization for the following purposes:

As Required by Law: We may use and disclose your health information when required to do so by federal, state or local law.

Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your health information 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.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement : We may disclose your health information, within limitations, to law enforcement officials for several different purposes:

- To comply with a court order, warrant, subpoena, summons, or other similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime, if unable to obtain the victim's agreement;
- About a death we suspect may have resulted from criminal conduct;
- About criminal conduct we believe in good faith to have occurred on our premises; and
- To report a crime, the location of a crime, and the identity, description and location of the individual who committed the crime, in an emergency situation.

Public Health Activities: We may use and disclose your health information for public health activities, including the following:

- To prevent or control disease, injury, or disability;
- To report births or deaths;
- To report child abuse or neglect;
- To report adverse events, product defects or problems;
- To track FDA-regulated products;
- To notify people and enable product recalls; and
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition.

Serious Threat to Health or Safety: If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank.

Coroners, Medical Examiners, and Funeral Directors: We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Workers' Compensation: We may disclose your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Military and Veterans Activities: If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so they may provide protective services for the President and others, including foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing you health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

Research: We may use and disclose your health information for certain limited research purposes. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project, assesses a number of specific issues, and determines that appropriate privacy safeguards are in place to allow the use of health information in the research project. We may, however, disclose your health information to people preparing to conduct a research project; for example, to help them look for patients with specific medical needs, so long as the health information they review does not leave the practice.

Other Uses and Disclosures of Your Health Information: Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will be made only with your authorization. If you authorize us to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by the revoked authorization, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health Information

You have the following rights regarding health information we maintain about you:

Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment or health care operations. **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 and submit it to the *Privacy Official at your local Texas Oncology office.*

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to the *Privacy Official at your local Texas Oncology office***.** We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes or information that is compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the Medical Records Department. If you request a copy of your health information, we may charge a fee for the costs of copying, mailing or preparing the requested documents.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

TEXAS ONCOLOGY

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the Privacy Official at your local Texas Oncology office.

We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us.

Right to an Accounting of Disclosures: You have the right to request an accounting of certain disclosures we make of your health information. Please note that certain disclosures, such as those made for treatment, payment or health care operations, need not be included in the accounting we provide to you.

To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the Medical Records Manager. Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to a Paper Copy of This Notice You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact our Business Office.

Right to Complain: If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to: Texas Oncology at 1 800-758-7608 and ask for the Privacy Officer. You may also file a complaint with the Secretary of the Department of Health and Human Services. **You will not be retaliated against or penalized for filing a complaint.**

Changes to this Notice

We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice in the Reception Area. Each version of the Notice will have an effective date listed on the first page. Updates are also available at our website, www.t exaso nco lo g y. co m.

Texas Breast Surgeons

CONSENT/AUTHORIZATION FOR RELEASE OF INFORMATION

1 I hereby authorize :

Name:____________________ Address:____________________

City:____________________ State:__________ Zip:__________

Phone:____________________ FAX:____________________

To release the following information from the health record (s) of

Patient's Name:____________________ Phone:____________________

Birth date:____________________

Covering the period (s) of treatment: From_______________ To:_______________

2. Information to be released:
   - ❑ Progress Note
   - ❑ Radiology
   - ❑ Lab
   - ❑ Billing Records
   - ❑ X-ray Films
   - ❑ Complete Medical Record (includes information regarding insurance, demographic, referral documents and records.)

   Mail Copies:__________
   Patient Pick-Up__________
   FAXED__________

3. Information is to be released to:

   Name____________________ Address:____________________

   City:____________________ State:__________ Zip:__________

   Phone:____________________ FAX:____________________

4. Purpose of disclosure (circle one): **Treatment Payment Health Care Operations Other (Specify Below)**

   ____

5. I understand that I may revoke this consent/authorization at any time by notifying Texas Oncology® in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information has acted in reliance upon this authorization.

6. **This authorization will remain in effect until revoked by me in writing, or on this date: _______________.**

7. The facility, its employees and officers, and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

8. I understand that according to applicable state and/or federal laws (Texas Medical Practice Act or Health Insurance Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment. I voluntarily sign this authorization, and I understand that my ability to obtain health care from Texas Oncology will not be affected if I refuse to sign this authorization.

Signature:______________________________ Date:_______________
Patient or Legal Representative

Witness: ______________________________ Relationship_______________