ATLANTA *Breast Care*

275 Collier Road NW, Suite 470, Atlanta, GA 30309
Phone: 404-351-1002 | Fax: 404-350-8290
www.atlantabreastcare.com
info@atlantabreastcare.com

Please complete these forms online or by hand, then print and bring them to your appointment. You may also scan and email them to **info@atlantabreastcare.com** or fax to **404-350-8290**. Please include a **copy of your insurance card** (front and back) with your completed New Patient paperwork.

We look forward to seeing you in our office.

Thank you!

William A. Barber, MD, FACS
Erin Bowman, MD
Amanda Morehouse, MD, FACS

Anna Deriso, RNC, WHNP, MSN
Kristy Donaldson, PA-C
Lauren McDermott, PA-C
Jennifer Munn, RN, CBCN

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First Name | MI | Last Name | Preferred Name

SSN | Birth Date | Email Address *(required for Portal Access)*

Address

City | State | Zip

PLEASE CHECK YOUR PREFERRED CONTACT NUMBER BELOW (Check ONE only)

☐ Home ☐ Work ☐ Cell

Marital Status: S ☐ M ☐ D ☐ W ☐ Significant other's name: _____

Emergency Contact | Relation | Contact Number

Primary insurance policy holder if other than patient:

Name | Relation | Birth Date

Responsible Party if other than patient | Relation | Contact Number

I hereby authorize Atlanta Breast Care to bill my insurance carrier for any services rendered by any agents of the practice. With this authorization I assign any and all benefits payable for services rendered by Atlanta Breast Care or agents of the practice. I understand that I am responsible for any amount not covered by my insurance plan.

I hereby authorize the release of any and all medical information necessary to the treatment I receive while under the care of Atlanta Breast Care. I authorize the release of medical information including x-rays, pathology, laboratory and operative reports to Atlanta Breast Care. A copy of this authorization shall be valid as the original.

Patient or Guardian Signature | Date

ATLANTA *Breast Care*

FINANCIAL POLICY

INSURANCE

It is the patient's responsibility to provide the most current insurance information available. In the event that we are provided with incorrect insurance information, the patient will be responsible for the balance. Any deductible, co-pay or co-insurance required by your insurance will be collected at the time of service. To assist you in filing your own insurance claim, we will provide you with an itemized statement.

We will submit claims to your insurance company on your behalf. You are responsible to ensure that we have a current referral on file, if required by your insurance company. While we have participation agreements with most carriers, you are responsible to know its limitations and reimbursement levels. If we do not participate with your insurance carrier we require payment at the time of service for office visits and procedures.

NO SHOW POLICY

A "no-show" is someone who misses an appointment without cancelling 24 hours in advance. We reserve the right to bill you a $50 no-show fee.

SURGERY

Any deductible, co-insurance, or out of pocket expenses should be paid in full prior to surgery.

FEES FOR NON-PHYSICIAN SERVICES

Returned check fees are $40. A billing fee of $2.50 will be added to all account balances carried from one month to the next. The fee for completion of forms including disability forms, cancer policy claim forms, letters for cancellations of airline reservations, excuses from services such as jury duty, etc. is $25. Additional form completions are $15. We follow the State of Georgia's fee schedule for copies of medical records.

ACCOUNT BALANCES

Payments can be made with cash, check, credit card, or money order. Account balances will be kept open for no longer than 120 days. After 120 days, unpaid balances including incurred interest, will be turned over to an outside collection company, the undersigned is required to pay all collection fees, including, but not limited to legal/ attorney's fees.

QUESTIONS?

If you have any questions about our financial policy or your insurance reimbursement, please feel free to discuss them with our business office staff.

I have read and understand my financial responsibilities under this policy.

Patient or Guardian Signature

Date

Written Acknowledgement of Receipt of Notice of Privacy Practices

Notice of Privacy Practices can be found on our website or provided for your review in our office.

Please select **ONE** of the following:

I, _____, have reviewed a copy of Atlanta Breast Care's Notice of Privacy Practices.
Patient Name

I, _____, decline to review a copy of Atlanta Breast Care's Notice of Privacy Practices.
Patient Name

_____ _____
Patient or Guardian Signature Date

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MALE NEW PATIENT

Name _____ Today's date _____

Reason for today's visit _____

Occupation _____ Employer _____

Height _____ Weight_____ Referring Physician: _____

List of Current Physicians: _____

_____

Have you or any family member been tested for the "breast cancer gene" (BRCA 1 or 2)?

☐ No ☐ Yes Results if known: _____

Year of Testing? _____

SOCIAL HISTORY

Average caffeine intake / **quantity**: ☐ Daily _____ ☐ Weekly _____ ☐ Rarely _____ ☐ None

Average alcohol intake / **quantity**: ☐ Daily _____ ☐ Weekly _____ ☐ Rarely _____ ☐ None

Do you smoke tobacco? ☐ Yes, currently ☐ Yes, previously ☐ No

If yes, how much _____ for how long _____

If applicable, when did you quit?_____

Do you smoke marijuana? ☐ Yes, currently ☐ Yes, previously ☐ No

Do you use illicit substances? ☐ Yes, currently ☐ Yes, previously ☐ No

If yes, what type? _____

Do you use performance enhancing supplements/vitamins?

☐ Yes, currently ☐ Yes, previously ☐ No If yes, what type? _____

FAMILY CANCER HISTORY > Please specify the type of cancer if "other" is checked.

Cancer Type	*(circle one)*	Relation	Age at diagnosis	Living	Age at death
☐ Breast ☐ Other_____	maternal/paternal	_____	_____	☐ Yes ☐ No	_____
☐ Breast ☐ Other_____	maternal/paternal	_____	_____	☐ Yes ☐ No	_____
☐ Breast ☐ Other_____	maternal/paternal	_____	_____	☐ Yes ☐ No	_____

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Medical History

Name _____ Today's date _____

If you have ANY of the following medical issues please check (or complete where applicable):

☐ Cancer	Type	Year Diagnosed
☐ Autoimmune Disease	Type	Year Diagnosed
☐ Bleeding/Clotting Disorder	Type	Year Diagnosed
☐ Skin Problems	Type	Year Diagnosed
☐ Thyroid Disease	Type	Year Diagnosed

☐ Anemia	☐ Gout	☐ Kidney Disease
☐ Arthritis/Osteoarthritis	☐ Heart Disease	☐ Kidney Stones
☐ Asthma	☐ Heart Murmur	☐ Liver disease
☐ COPD	☐ Hepatitis	☐ Migraines
☐ Coronary Artery Disease	☐ High Blood Pressure	☐ Pulmonary Embolism
☐ Deep Vein Thrombosis	☐ High Cholesterol	☐ Seizures
☐ Diverticulitis	☐ HIV/AIDS	☐ Stroke
☐ GERD/Reflux	☐ Irregular Heart Rate/Rhythm	
☐ Sleep Apnea: (circle one) CPAP or APAP	☐ Diabetes: (circle one) Type I or Type II	

Please list any surgeries (ie: oral, orthopedic, etc.) and **include month/year of surgery:**

_____

_____

_____

Do you have an allergy to any medications? ☐ Yes ☐ No

If yes, please list the drug and the reaction: _____

_____

Current medications/vitamins:

Name Dose Frequency

_____

_____

_____

_____

_____

Other relevant info:

_____

_____

_____

_____

_____