# ATLANTA *Breast Care*

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First Name MI Last Name Preferred Name

SSN Birth Date Email Address

Address

City State Zip

☐ Home ☐ Work ☐ Cell

**PLEASE CHECK YOUR PREFERRED CONTACT NUMBER**

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.

**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 $40.00. 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 $25.00. Additional form completions are $15.00. 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.

**No Show Policy:** A "no –show" is someone who misses an appointment without cancelling it 24 hours in advance. We reserve the right to bill you a $50.00 no-show fee.

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 Signature _____ Date_____

ATLANTA *Breast Care*

# Written Acknowledgement of Receipt of Notice of Privacy Practices

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

_____ _____
Signature of Patient Date

**Male New Patient**

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Name _____ Today's date _____

Occupation _____ Employer _____

Height _____ Weight _____

List of Current Physicians _____

_____

Reason for today's visit**:** _____

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

☐ No ☐ Yes Results if known:

**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 steroids?

☐ Yes, currently ☐ Yes, previously ☐ No

Do you use performance enhancing supplements / vitamins?

☐ Yes, currently ☐ Yes, previously ☐ No

**Family Cancer History:** *Please specify the type of cancer if "other" is checked*

| Cancer Type | Relation | | Age at diagnosis | Living |
|---|---|---|---|---|
| ☐ Breast / ☐ Other _____ | maternal / paternal | _____ | _____ | ☐ Yes / ☐ No |
| ☐ Breast / ☐ Other _____ | maternal / paternal | _____ | _____ | ☐ Yes / ☐ No |
| ☐ Breast / ☐ Other _____ | maternal / paternal | _____ | _____ | ☐ Yes / ☐ No |
| ☐ Breast / ☐ Other _____ | maternal / paternal | _____ | _____ | ☐ Yes / ☐ No |
| ☐ Breast / ☐ Other _____ | maternal / paternal | _____ | _____ | ☐ Yes / ☐ No |

**Medical History**

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Name_____ Today's date_____

If you have ANY of the following medical issues please check

| | | |
|---|---|---|
| ☐ High Cholesterol | ☐ Cancer | ☐ Depression |
| ☐ High Blood Pressure | ☐ Autoimmune Disease | ☐ Anxiety Disorder |
| ☐ Heart Disease | ☐ Bleeding / Clotting disorder | ☐ Migraines |
| ☐ Coronary Artery Disease | ☐ Anemia | ☐ Liver disease |
| ☐ Stroke | ☐ Gout | ☐ PCOS |
| ☐ Heart Murmur | ☐ Skin Problems | ☐ Thyroid Disease |
| ☐ Irregular Heart Rate / Rhythm | ☐ Arthritis / Osteoarthritis | ☐ Diabetes |
| ☐ Asthma | ☐ Hepatitis | ☐ Kidney Disease |
| ☐ Sleep Apnea | ☐ HIV / AIDS | ☐ Kidney Stones |
| ☐ COPD | ☐ Pulmonary Embolism | ☐ GERD / Reflux |
| ☐ Seizures | ☐ Deep Vein Thrombosis | ☐ Diverticulitis |

☐ Other: _____

If you checked any of the above, please explain:_____

_____

Please list any **surgeries** you have had:_____

_____

_____

_____

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

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

_____

**Current medications:**

Name Dose Frequency

_____

_____

_____

_____

_____

_____

**Other relevant info:**

_____

_____

_____

_____

_____

_____