

Comprehensive Breast Care Center of West Georgia
Carrollton Surgical Group, P.A.

CHART #: _____

DATE: ____/____/____

MEDICAL HISTORY

NAME: _____ **BIRTH DATE:** _____

REASON FOR VISIT: [] Abnormal mammogram [] Breast lump [] Breast pain
(check all that apply) or ultrasound
[] Nipple discharge [] Other: _____

REFERRING MD: _____ **PRIMARY MD:** _____

DATE OF LAST MAMMOGRAM: _____ **Where:** _____

MEDICINE ALLERGIES: [] None _____

CURRENT MEDICATIONS: [] None _____

OTHER (vitamins, herbal (natural) products, over the counter): _____

MEDICAL PROBLEMS: [] None
(check all that apply) [] High blood pressure [] Heart disease [] Lung problems
[] Diabetes-Treated by: [] Pill [] Insulin [] Diet [] Stroke
[] Bleeding problems [] Kidney problems [] HIV [] Hepatitis
[] Stroke [] Thyroid problem [] Other: _____

[] Have YOU had breast cancer? (explain): _____

[] Have YOU had other cancers? (explain): _____

PAST SURGERIES AND DATES: _____

DO YOU SMOKE? [] No If Yes, how many packs per day? _____

Used to smoke, quit _____ years ago.

Signature

Date

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DO YOU USE ALCOHOL? No

If yes, do you have drink(s) on a daily basis?(circle) Yes No

FAMILY HISTORY OF BREAST CANCER: **No history of breast cancer in family**

Mother (age at diagnosis:____) Father Brother

(Check all that apply) Sister(s)-(How many____, age(s) at diagnosis:_____)

(Aunts and grandmothers Aunt(s)-(How many____, age(s) at diagnosis_____)

from both sides of family) Grandmother(s) Others:_____

FAMILY HISORY(continued)

Ovarian Cancer- Relationship to you:_____

Other recurrent cancers in the family: _____

Hypertension **Heart Disease** **Diabetes** **Strokes**

GYNECOLOGICAL & OTHER HISTORY

Last Menstrual Period:_____ **Age periods started:**_____

Age at Menopause:_____ **Hysterectomy?** No **If yes, at what age?**_____

Ovaries removed? No One Both

Are you on hormone replacement therapy (HRT)? No

If yes, name:_____ **For how long?**_____

Have you been on HRT in past but not now? No Yes

Name of drug and for how long :_____

Have you ever been treated with hormones for infertility? No

Yes, explain:_____

How many times have you been pregnant?_____

How many times have you given birth? _____

Your age at the birth of first child: _____

Did you breast feed? No Yes **For how long?** _____

Number of cups of caffeinated coffee per day?_____ **caffeinated sodas?**_____

Do you have any other general health and/or breast health concerns? _____

My signature below indicates I have disclosed all of my known medical condition, medications and past medical problems.

Signature

Date

**Comprehensive Breast Care Center of West Georgia
Cancellation Policy
Effective March 2008**

Cancellation Charge for Surgeries at Hospital:

In the event that your surgery is cancelled within 5 days of the scheduled surgery there will be a \$100.00 charge for which you will be responsible. The charge will only be waived under circumstances which are determined to be the result of an emergency. The decision to waive the cancellation charge will be determined by our office. If you feel sick prior to your surgery please contact our office Monday thru Friday between the hours of 7:00 a.m. and 6:00 p.m. The telephone number is 770.834.3336. You will need to speak to a nurse regarding the symptoms you are having so that they can assist you. There could very likely be a solution to the problem without canceling your scheduled surgery. If you have problems after office hours and your surgery is scheduled for the following morning please go to the hospital as scheduled and let the anesthesiologist decide if you are qualified to proceed with surgery. There are different preparations for scheduled surgeries which have to be followed closely. Please pay careful attention to the instructions our office gives you so that you can avoid doing something which may result in your not being prepared for surgery. If failure to comply with the proper instructions to prepare you for a surgery is the cause of a surgery cancellation there will be a \$100.00 cancellation fee for which you will be responsible. Please note that a preparation sheet indicating that the patient is to eat nothing or drink nothing after midnight means that you can not put anything in your mouth after midnight. This statement includes peppermint drops, chewing gum, tobacco, etc. If you are unsure at any time about the proper preparations for your surgery please call our office and speak with a nurse.

Cancellation Charge for Scheduled Procedures in the Office:

There will be a \$50.00 charge for cancellation of a procedure scheduled to be done in the office if the procedure is cancelled within 5 days of the scheduled procedure for which you will be responsible. This charge will only be waived under circumstances which are determined to be the result of an emergency. The decision to waive the cancellation charge will be determined by our office.

This is to certify that I fully understand the Cancellation Policy of Comprehensive Breast Care Center of West Georgia, and, in addition I understand the proper procedure to prepare for my surgery and the necessity of following these instructions precisely. I further agree to contact the office to speak with a nurse to clarify any questions that may arise.

Patient Signature

Date

Witness

**COMPREHENSIVE BREAST CARE CENTER OF WEST GEORGIA
FINANCIAL POLICY
EFFECTIVE NOVEMBER 2008**

Insurance: If we participate with your insurance carrier, our office will file a claim on your behalf for all charges. However, we will collect the required co-payment *before* services are rendered. In the event a health plan determines a service to be “non-covered”, the patient will be responsible for all charges. Many insurance policies require a co-insurance payment which is due from the patient for certain surgical procedures and office services. We have to estimate what this amount is and the actual amount due may be more or less than the initial estimate. We require that this percentage amount be paid *prior* to surgery. Any overpayment will be refunded to the patient and any amount due will be billed to the patient. If you present invalid insurance coverage you will be held responsible for payment in full on your account. We accept cash, checks, traveler’s checks, all major credit cards and debit cards in payment on your account. We can also assist you with obtaining an interest free loan thru Care Credit. We will be glad to assist you in arranging an acceptable method of payment.

Comprehensive Breast Care Center off West Georgia employs a Physician’s Assistant. Occasionally circumstances arise in which the Physician’s Assistant may assist with surgery. All insurance companies do not pay for the services of a Physician’s Assistant. The patient will be held responsible for payment of those services. The patient may choose not to have the Physician’s Assistant assist with surgery. Your request will need to be presented to the office before your surgery is scheduled and you must keep in mind that your surgery may have to be postponed if another surgeon is not available to assist the primary surgeon.

Some members of our nursing staff are Medical Assistants. Please let the nurse know if you wish to speak with an LPN.

This is to certify that I authorize a representative from Carrollton Surgical Group, P. A. to act on my behalf in an effort to appeal my claim for medical benefits with my insurance company. ****Initial** _____

Self-Pay: A \$200.00 minimum is required for office visits for patients who do not have health coverage. All procedures will require a down payment which will be determined at the time of scheduling.

Minor Patients: For all services rendered to minor patients, the adult accompanying the patient will be held responsible for payment of all charges.

Payments: Payments are due on a monthly basis. If a patient fails to make a scheduled payment, the *total* balance will be expected within ten days. Should a patient at any time disregard our payment policy, the amount due will be forwarded to magistrate court and an appropriate amount will be added to the balance due on the account. Your employer may be contacted to verify employment.

FMLA Forms, Cancer Insurance Forms, Disability Forms and Copies of Medical Records: If you require completion of FMLA Forms, Cancer Policy Insurance Forms or forms related to Disability claims there will be a \$10.00 charge which must be paid at the time the forms are picked up or in advance if you would like the forms to be mailed. There is a fee which is set forth by the State of Georgia which will be charged for copying medical records.

Our main goal is to provide quality patient care and we need your cooperation in order to make that possible. Please note that if you cancel your surgery within two days of the scheduled surgery date it will be necessary for you to schedule an office visit with your doctor prior to rescheduling the surgery.

By signing below, the patient agrees to the terms of our financial policies and we appreciate your cooperation.

Signature of Patient or Responsible Party

Please Print the Name of the Patient

Date: _____