

Please Mail To: PRESTONWOOD IMAGING CENTER
6957 W. Plano Pkwy. Suite 1100
Plano, TX 75093
PH: 972-395-7533 FAX: 972-395-7536

MAMMOGRAPHY CONSENT FORM / RELEASE OF FILMS

PERSONAL INFORMATION

Last Name: _____ First Name: _____ MI: _____
Address: _____ City: _____
State: _____ Zip: _____ Social Security Number _____
Phone: _____ Cell: _____
Work Phone: _____ Date of Birth: _____ Age: _____

ORDERING PHYSICIAN INFORMATION

Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

By signing this form, you authorize employees, including physicians, physician's assistants and nurse practitioners, imaging technologists, including consultants, associates, and assistants of the physicians' choice to coordinate your care.

You understand that you are responsible for the total charges for services rendered which may include services not covered by your insurance companies. You agree that all amounts are due upon request and are payable to Prestonwood Imaging. You further understand should your account become delinquent, you shall pay the reasonable attorney fees or collection expenses of Prestonwood Imaging, if any.

By signing this form, you consent to Prestonwood Imaging release and/or disclosure of your medical information for treatment, payments, health care operations, and as otherwise allowed by law. This includes any medical service or visit, Diagnostic testing ordered by the physician or the physician's staff.

The duration of this consent is indefinite and continues until revoked in writing.

AUTHORIZATION TO OBTAIN PRIOR MAMMOGRAPHY STUDIES/REPORTS

I AUTHORIZE _____ TO RELEASE MY

NAME OF PREVIOUS FACILITY

MAMMOGRAPHY FILMS TO PRESTONWOOD IMAGING.

PRIOR MAMMOGRAM DONE ON: _____
(DATE)

(Signature of Patient or Legal Representative)

(Date)

SCREENING MAMMOGRAPHY HISTORY

Patient Name: _____ Date of Birth: _____

PLEASE ANSWER ALL QUESTIONS

1. Have you ever had a mammogram? Y N

2. Name of the facility where you had your last mammogram? _____

City/State _____ Phone _____

3. **WHEN** was your last mammogram? (month/year) _____

4. Have you ever had any:

Breast Biopsy Y N Rt _____ Lft _____ Year _____

Type of Biopsy: Surgical _____ Needle _____ Benign? Y N

Implants Y N Rt _____ Lft _____ Year _____

Reduction Y N Rt _____ Lft _____ Year _____

Mastectomy Y N Rt _____ Lft _____ Year _____

5. Have you ever had **breast** cancer? Y N Rt _____ Lft _____ Year diagnosed: _____

6. Any family history of breast cancer? Y N

Grandmother/Age Diagnosed _____ Mother/Age _____

Sister/Age _____ Aunt/Age _____

7. **ANY CHANCE OF PREGNANCY?** Y N

8. Date of your last period **OR** menopause? _____ Age at first period? _____

9. Have you ever given birth? Y N Age when you had your first child? _____

10. Are you on Hormone Replacement Therapy? Y N How Long? _____ years

11. Are you taking birth control? Y N How Long? _____ years

12. Are you having any breast symptoms or problems at this time? If so, explain.

Prestonwood Imaging Center

6957 West Plano Parkway, Suite 1100

Plano, Texas 75093

Office 972.395.7533

Fax 972.395.7536

Clinic: 519

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ Date of Birth: _____ Date of Visit: _____

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree that it is my responsibility and not the responsibility of the physician or clinic to know if my insurance will pay for my medical service or visit, preventative exam or physical, lab testing, x-ray, EKG, or any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or a higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree that it is my responsibility to know if my PCP (primary care physician) choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Patient's Signature: _____ Date: _____
(please sign here-Patient or Responsible Party)

Responsible Party Name: _____
(please print name of Responsible Party if different from Patient)