MEMORIAL WOMEN'S CENTER (MEMORIAL MRI & DIAGNOSTIC)

Patient's Name: ___________________________ **Sex:**_____________________________ **DOB:** ______________

SS# _______________________ **Address:** ____

City /State/ Zip: ____

Home #: ___________________________ **Work #:** ____________________ **Cell #:** _______________________

Insurance Name: ________________________________ **ID#:** _______________________ **Group #:** ___________

Primary Card Holder if not Patient: _______________________________________**DOB:** _____________________

SS# _____________________________**WORKER'S COMP INFO: Employer:** ______________________________

Date of Injury: ____________**Address:** ___________________________ **City / State/ Zip:** __________________

Contact Person: ___________________________ **Work #:** _______________________ **Fax #:** ________________

Attorney's Name: ____________________________ **Office #:** _________________ **Fax #:** _________________

Treatment & Insurance Authorization

Authorization for Release of Information and Assignment of Benefits

I hereby authorize Memorial Women's Center dba Memorial MRI & Diagnostic to bill my insurance company directly for the services rendered. I understand that I am financially repsonsible for charges not covered by my insurance company. I hereby assign to the above named office, those benefits otherwise payable to me and by any third party as reimbursement of expenses and fees in connection with treatment rendered. I request that payment of authorized benefits be made directly to the medical provider named above on my behalf.

Authorization for Treatment

You are responsible for the payment of co-payment, co-insurance, non-covered services, or any patient responsible balance at the time of service. If you are covered by a plan in which we participate as a provider, we will file your insurance claim. In the event your insurance company does not pay the full balance, we will notify you so that you may contact your insurance carrier or resolve your account. Please remember payment responsibility rests with the patient, if no coverage exists for services performed.

- All non-covered patients are expected to pay for services in full at the time the services are rendered.
- Please advise the office personnel of any changes in your insurance or mailing address.
- Should it ever become necessary to use the services of an outside collection agency to collect your account, you could be responsible for any costs incurred for that purpose.

PATIENT SIGNATURE:_____________________________**Date:** ___________________

Medical Records Authorization

I hereby authorize the release of my films and /or medical records as needed for subsequent medical care. In the eve nt of postive findings, I authorize my attending physician to release the results of my biopsy-surgery to the provider named above for their records.

I hereby request that any MEDICAL RECORDS be released to:

MEMORIAL WOMEN'S CENTER		MEMORIAL MRI & DIAGNOSTIC	
8800 Katy Freeway Suite #105		1241 Campbell Road	
Houston, Texas 77024		HOUSTON, TEXAS 77055	
Office #: 713-461-3399	Fax #: 713-461-1969	Office #: 713-461-3399	Fax #: 713-461-1969

IF SOMEONE OTHER THAN THE PATIENT IS SIGNING THIS AUTHORIZATION, PLEASE STATE RELATIONSHIP WITH PATIENT AND THE REASON PATIENT IS UNABLE TO SIGN: ____
____

Office Use Only: Information Requesting: □ MRI REPORTS □ MRI FILMS □ ULTRASOUND REPORTS □ ULTRASOUND FILMS □ NUCMED FILMS □ NUCMED REPORTS □ CT REPORTS □ CT FILMS □X-RAYS/FLOURO REPORTS □ X-RAYS/FLOURO FILMS □ MAMMO FILMS □ MAMMO REPORTS □ DEXA/BD REPORTS □ DEXA/BD FILMS

□ Other Healthcare Information to the following treatment, condition, or date of treatment:

PATIENT SIGNATURE: **Date:**

Memorial Women's Center — Memorial MRI & Diagnostic

Health Survey for Screening/Diagnostic Mammogram

Dear Patient,
Welcome to Memorial Women's Center. Please read and complete these pages carefully. They are necessary for us to be able to provide you with the best possible care. Some information may seem redundant, but the format is necessary for completeness. This format requires short answers only. Words in bold type are choices to be circled when appropriate.

(PLEASE ANSWER ALL QUESTIONS AND QUPDATE ANY NEW INFORMATION) DATE: ___________

NAME:	**SS#:**	**DOB:**	**AGE:**
ADDRESS:			

HOME PHONE:	**WORK PHONE:**	**REFERRING PHYSICIAN:**	**EXAM DATE:**

REASON FOR EXAM PLEASE DESCRIBE ANY PROBLEMS YOU ARE HAVING WITH YOUR BREASTS:

PREVIOUS MAMMOGRAMS IS THIS YOUR FIRST MAMMOGRAM? YES NO IF NO, WHEN AND WHERE HAVE YOU HAD A MAMMOGRAM?

MEDICAL HISTORY AGE AT HYSTERECTOMY AND/OR OVARY(S) REMOVED, IF ANY:

NUMBER OF PREGNANCIES: ________ DATE OF LAST PERIOD: ___________

NUMBER OF DELIVERIES: ________ AGE AT FIRST PERIOD: ______

AGE AT FIRST DELIVERY: ________ AGE AT MENOPAUSE: ______

ORAL CONTRACEPTIVE USE

NUMBER OF MONTHS OF USE: _________

PERSONAL HISTORY
HAVE YOU HAD BREAST CANCER?
IF YES, PLEASE DESCRIBE:

HAVE YOU HAD NON-BREAST CANCER?
IF YES, PLEASE DESCRIBE:

PLEASE INDICATE THE DATE AND SIDE OF EACH OF THE FOLLOWING: MASTECTOMY, LUMPECTOMY, CYST ASPIRATION, BIOPSY, RADIATION THERAPY, BREAST RECONSTRUCTION, BREAST IMPLANTS AND BREAST REDUCTION:

PROCEDURE	SIDE	DATE

RIGHT BREAST 12 9 3 6 — LEFT BREAST 12 9 3 6

FAMILY HISTORY
HAS ANY BLOOD RELATIVE HAD BREAST CANCER? YES NO IF YES, PLEASE LIST EACH & THEIR RELATIONSHIP TO YOU:

HAS ANY BLOOD RELATIVE HAD OVARIAN CANCER? YES NO IF YES, PLEASE LIST EACH & THEIR RELATIONSHIP TO YOU:

HORMONE USE TYPE/AGE AT FIRST USE/NO. OF MONTHS OF USE:

IMPLANTS

COMMENTS

SIGNATURE
I ATTEST THAT THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO CONSENT FOR PATIENT DATE TECHNOLOGIST

Memorial MRI & Diagnostic & Memorial Women's Center

NOTICE OF PRIVACY PRACTICES

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.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At **Memorial MRI & Diagnostic Imaging** **(hereinafter referred to as "the Practice"),** privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide services to you, to process your claims and to bring your health information that might be of interest to you.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us as the telephone numbers or addresses listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How – and why – information is shared

We limit who receives information and what type of information is shared.

- *Sharing information within* ***the Practice.*** We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.
- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.
- *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy.

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us – whether it's at our office, over the phone or through the Internet.

Memorial MRI & Diagnostic
1346 Campbell Road
Houston, Texas 77055
(713) 461 - 3399

Memorial MRI & Diagnostic
1241 Campbell Road
Houston, Texas 77055
(713) 461 - 3399

Memorial Women's Center
8800 Katy Freeway Suite #105
Houston, Texas 77024
(713) 461-3399

Memorial MRI & Diagnostic / Memorial Women's Center

NOTICE OF PRIVACY PRACTICES

Patient Consent and Acknowledgment of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, **Memorial MRI & Diagnostic** creates and maintains health records and other information describing among other things, my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must: agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

______________________________ (PATIENT'S NAME PRINTED)

______________________________ DATE

______________________________ PATIENT'S SIGNATURE
(OR GUARDIAN, IF A MINOR)