M·U·S·I·C
Mammography & UltraSound
Imaging Center, PLLC

John M. Elliott, M.D.

Judy M. Yancey, M.D.

PATIENT INFORMATION FORM			
MRN:		Appt Date:	Appt Time:
Last Name:		Social Security #:	
First Name:	Mid. Initial:	Date of Birth:	
Home Address:		Age:	Sex:
Home Address 2:		Home Phone #:	
City, State, Zip:		Work Phone #:	
PT Email:		Cell Phone #:	
Referring Provider:		Referring Phone #:	
Primary Care Physician:			
EMGERGENCY CONTACT INFORMATION: In case of emergency who should be notified?			
Name:		Tel #:	
CONSENT TO RELEASE PROTECTED HEALTH INFORMATION (PHI) TO THE FOLLOWING PERSON(S):			
Name:		Relationship:	
Name:		Relationship:	
Name:		Relationship:	
PRIMARY INSURANCE			
Plan Name:		Group #:	
Plan Tel #:		Subscriber DOB:	
Subscriber Name:		Subscriber ID/Policy #:	
Relationship to Patient: ☐Self ☐Wife ☐Husband ☐Parent ☐Other			
SECONDARY INSURANCE			
Plan Name:		Group #:	
Plan Tel #:		Subscriber DOB:	
Subscriber Name:		Subscriber ID/Policy #:	
Relationship to Patient: ☐Self ☐Wife ☐Husband ☐Parent ☐Other			

Assignment of Insurance Benefits

I authorize payment of medical benefits to: Mammography and Ultrasound Imaging Center, PLLC for services rendered. I also authorize the release of any medical information necessary to process my insurance claims. I request and authorize that payment/insurance benefits be made directly to Mammography and Ultrasound Imaging Center, PLLC any services furnished to the above named patient by Mammography and Ultrasound Imaging Center, PLLC. The signature below shall suffice for all insurance forms on a continuing basis. I agree to pay Mammography and Ultrasound Imaging Center, PLLC for all charges for services not covered by Insurance Payer.

Patient or authorized person's signature: _____ **Date:** _____

7550 W University Avenue, Suite A | Gainesville, FL 32607 | Tel: (352) 727-4911 Fax: (352) 505-5211
www.mammographyandultrasoundimagingcenter.com

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BREAST QUESTIONNAIRE

MRN: Appt Date: Appt Time:

Patient Name:

Date of Birth: Age: «PatientAge» Sex: «PatientSex»

Age of First Menstrual Period: _____ Menopause Age: _____ NATURAL SURGICAL

NEW lumps in breast?	NO	YES	RIGHT	LEFT
NEW pain or discomfort?	NO	YES	RIGHT	LEFT
NEW discharge from nipple?	NO	YES	RIGHT	LEFT
Do you have breast implants?	NO	YES	SALINE	SILICONE
Any previous breast surgeries?	NO	YES	RIGHT	LEFT

If yes, age: _____

Type of surgery: _____

Results: _____

Are you taking Estrogen? NO YES

FAMILY history of BREAST cancer? NO YES

If yes, relationships? _____

Maternal Paternal

Personal history of BREAST cancer NO YES

Have YOU had a personal history of OTHER types of cancer? NO YES

If yes, what type? _____

Have you had a mammogram before? NO YES

If yes, what facility? _____

When? _____

To the best of my knowledge the above information is correct.

Signature: _____ Date: _____

CONTINUED ON PAGE 2

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Digital Screening Mammograms

I understand that if additional views are required for complete diagnosis; a Digital DIAGNOSTIC mammogram may be billed in addition to the Digital SCREENING mammogram.
Additionally if a breast ultrasound is performed it may be added and will be reflected in the charges.

Patient's Signature: _____ Date: _____

Medicare Limitation of Liability

Medicare will only pay for services it determines to be "reasonable and necessary" under Section 1862(A)(1) of the Medicare law. If Medicare determines that a particular service is NOT "reasonable and necessary" under Medicare program standards, Medicare may deny payment for the following reason:

Under Medicare rules, screening mammograms are allowed and payable once every 12 months for women age 40 and over.
For women under age 40, Medicare allows one screening mammogram every 24 months.

PROCEDURE CODE	CHARGE	POSSIBLE REASON FOR DENIAL
G0202 (Screening)	$ 272.00	See above
77052 (CAD)	$ 21.00	See above

Patient's Signature: _____ Date: _____

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Consent to use, obtain, and disclose protected health information

Patient Name: DOB: PHONE:_____

I, «PatientFullName», hereby give my permission to Mammography and Ultrasound Imaging Center, PLLC to obtain my protected health information from others for the purpose of treatment, obtaining payment, or supporting the day-to-day operations of the practice.

I hereby give my permission to Mammography and Ultrasound Imaging Center, PLLC to use and disclose my protected health information disclosed by another covered entity for the purposes of treatment, obtaining payment, or supporting the day-to-day operations of the practice.

This release covers all my personal health information including but not limited to medical reports, progress notes, CDs, films, diagnostic studies, lab work, and any other documentation requested by Mammography and Ultrasound Imaging Center, PLLC for the purposes of treatment, obtaining payment, or supporting the day-to-day operations of the practice.

I understand that Mammography and Ultrasound Imaging Center, PLLC may request this information from health care providers, hospitals, ancillary service providers, and other entities. I understand that Mammography and Ultrasound Imaging Center, PLLC will use my personal health information solely for the purposes of treatment, obtaining payment, and supporting the day-today operations of the practice.

A copy of this release is as valid as the original. This is a lifetime release unless revoked by me in writing.

Facility Name: _____

Facility City/State: _____

Type of records: Mammography/Ultrasounds/Bone Density-Imaging and Report

Other records (be specific): _____

Name of Person Signing Below (PRINT): _____

Relationship to Patient: _____

Signature of Patient or Parent/Guardian: _____Date:_____

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CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS, AND CONSENT TO PERFORM SERVICES ORDERED

I, «PatientFullName» understand that as part of my health care, ***Mammography & Ultrasound Imaging Center, PLLC*** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent;
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that ***Mammography & Ultrasound Imaging Center, PLLC*** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that ***Mammography & Ultrasound Imaging Center, PLLC*** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should ***Mammography & Ultrasound Imaging Center, PLLC*** change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I UNDERSTAND THAT BY SIGNING THIS FORM I AM CONSENTING TO THE SERVICES ORDERED
I fully understand and accept / decline the terms of this consent.

(Circle one)

Patient's Signature: _____ Date: _____

FOR OFFICE USE ONLY **MRN:**

[ ] Consent received by_____ on _____

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on_____

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Directions to our Office

7550 W University Ave, Suite A, Gainesville, Fl 32607

From Newberry Rd/State Rd 26:

1. Turn onto NW 75th St (Tower Rd) and proceed 0.4 miles
2. Turn right onto W University Ave
3. Take the third right and your destination will be on the left

From SW Archer Rd:

1. Turn onto SW 75th St (Tower Rd) and proceed 3.8 miles
2. Turn left onto W University Ave
3. Take the third right and your destination will be on the left.

If you have any questions about our location please feel free to call us at (352)727-4911. We will be happy to assist you.