Tampa Bay Breast Care Specialists, LLC

John Myrrh Cox, M.D., Surgical Oncologist

3000 Medical Park Drive, Suite 140
Tampa, FL 33613
(813) 978-8315 Fax: (813) 600-6962

4211 Van Dyke Road, Suite 207
Lutz, FL 33558
http://www.tampabreastcare.com

Thank you for choosing Tampa Bay Breast Care Specialists.

Appointment Location:

Life Hope Medical Office Building
3000 Medical Park Drive, Suite 140
Tampa, FL 33613

St. Joseph's Hospital - North
4211 Van Dyke Road, Suite 207
Lutz, FL 33558

Pre-Appointment Instructions

Please bring the following information with you to your appointment:

- Photo ID
- Insurance Card(s)
- Films and reports from the imaging center

  Bring your latest mammograms and ultrasounds, if applicable, along with the x-ray films. Patients need to call the facility where mammograms and/or ultrasounds were done and request them to be ready for pick up. Most facilities require at least a 48 hour advance notice.
- Completed paperwork (questionnaire)

Failure to bring imaging reports/films and completed paperwork may result in rescheduling your appointment.

Thank you!

Tampa Bay Breast Care Specialists Team

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PATIENT INFORMATION			
Today's Date:		Social Security #:	
First Name:	MI:	Last Name:	Suffix:
Sex: ☐ Female ☐ Male		Date of Birth:	Age:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated			
Ethnicity: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other			
Primary Language:			
Patient's Permanent Address:		Employment Status	
		☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled	
		☐ Unemployed ☐ Student	
City:		Employer's Name:	
State:	Zip:	Address:	
Home Phone:			
Work Phone:		City:	
Cell Phone:		State:	Zip:
Email address:		Phone:	
Who is your Primary Care Doctor?		Phone:	
Who referred you? (Referring Physician)		Phone:	

INSURANCE INFORMATION			
Do you have your own insurance? ☐ Yes ☐ No			
If no, who is financially responsible for your medical coverage?			
Address:		Guarantor's Date of Birth:	
City:	State:	Zip:	
Phone:			
Primary Insurance Carrier:		Secondary Carrier:	
Subscriber Social Security#		Subscriber Social Security#	
Subscriber's Name:		Subscriber's Name:	
Subscriber's Date of Birth:		Subscriber's Date of Birth:	
Subscriber ID #		Subscriber ID #	

EMERGENCY CONTACT INFORMATION	
Name:	Relationship to Patient:
Social Security Number (for verification only):	
Home Phone:	
Work Phone:	
Cell Phone:	

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BREAST INFORMATION

Pregnancy Information:

Age of first pregnancy:	Did you breast feed? ☐ Yes ☐ No
Number of living children:	

Menstrual Cycle Information:

Your age when you had your first period?	Are your periods regular? ☐ Yes ☐ No
Date your last period began:	Your age at menopause?

Do you have difficulties with your periods? ☐ Yes ☐ No

Personal History of Breast Cancer:

Have you ever had breast cancer before? ☐ Yes ☐ No

When was your cancer treated?

What type of cancer treatment did you receive? ☐ Chemotherapy ☐ Radiation Therapy ☐ Surgery

Birth Control Information:

Have you ever taken birth control pills? ☐ Yes ☐ No If yes, when and for how long?

Hormone Therapy:

Have you ever taken hormone pills? ☐ Yes ☐ No If yes, when and for how long?

What drug (e.g. Premarin/ Prempro)?

Tests:

Do you perform breast self-exams? ☐ Yes ☐ No

When and where was your last mammogram?

When and where was your last pap smear?

Current Problem		When did you first notice a problem?
Lump you can feel	☐ Yes ☐ No	
Pain	☐ Yes ☐ No	
Nipple Discharge	☐ Yes ☐ No	
Breast Trauma	☐ Yes ☐ No	
Abnormal Mammogram	☐ Yes ☐ No	
Other	☐ Yes ☐ No	

I certify that, to the best of my knowledge, the above information is complete and accurate.

Patient's Signature:	Today's Date:

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MEDICAL HISTORY INFORMATION

Current Medications (Please list all medications / dietary supplements / herbal / alternative medications and treatments you are currently taking)

Medication	Dosage	# Per Day / Frequency	Reason for Taking
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Medication Allergies - Are you allergic to any medications? ☐ Yes ☐ No

Medication	Reaction

Do you have an allergy to any latex products? ☐ Yes ☐ No

Have you had an allergic reaction to tape (adhesives)? ☐ Yes ☐ No

Do you have any problems with anesthesia? ☐ Yes ☐ No

Past Surgical History- Please include any breast biopsies or breast augmentation, and which breast

Please list any operations you have ever had, and the approximate dates.

	Month/Year

PAST MEDICAL HISTORY INFORMATION

Have you ever had any type of cancer?	☐ No ☐ Yes	Type:
Have you ever had a heart attack?	☐ No ☐ Yes	Year:
Do you have a pace maker or stent?	☐ No ☐ Yes	Which:
Do you have high blood pressure?	☐ No ☐ Yes	
Do you have asthma, emphysema, chronic bronchitis or chronic lung disease? ☐ No ☐ Yes (If yes, please circle which ones)		
Do you have diabetes or high blood sugar?	☐ No ☐ Yes	Type:

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FAMILY HISTORY OF CANCER	
Has any family member been diagnosed with cancer? (For example: leukemia, ovarian, colon breast, pancreatic, melanoma, etc.)	☐ No ☐ Yes

If yes, please list family member(s) and cancer below, whether the person was on your mother's or father's side, and their approximate age when the cancer was found. Write on the back if you need more space.

Family Member	Type of Cancer	Age of Patient at diagnosis	Current status of patient

SOCIAL HISTORY		
Tobacco	☐ None ☐ Currently Smoke____ packs/day and have done so for ____ years. ☐ Previously smoked____ packs/day for ____ years. Date you stopped_____. ☐ Smokeless tobacco products	
Alcohol	☐ None ☐ Minimal ☐ Moderate ☐ Heavy ☐ Previously Heavy	
Caffeine	☐ None ☐ 1-3 Servings Daily ☐ 3-4 Servings Daily ☐ More than 6 servings daily	
Drug Use	☐	☐

Please use this space for any additional information you would like to communicate to the physician. Write on the back if you need more space.

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(Please Read Carefully)

SPECIAL ASSIGNMENTS/AUTHORIZATION - CONSENT TO TREATMENT

I hereby consent to and authorize the performance of all appropriate procedures and courses of treatment, the administration of all local anesthetic and/or blocks, and any and all medication and technical procedures, which in judgment of the health care provider attending and consulting may be considered necessary or advisable to treat:

Me_____ - OR – My_____/_____
(Print Name) (Relationship) (Print Name)

while a patient of a physician in the employment of Tampa Bay Breast Care Specialists.

In addition to the above:

- I consent to the appropriate disposal by Tampa Bay Breast Care Specialists of any specimens or other bodily materials removed during technical procedures or for testing purposes.
- I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantee has been made as to the results of any therapies and/or procedure(s).

PATIENT VALUABLES

Tampa Bay Breast Care Specialists does not accept responsibility for any personal property (monetary or sentimental).

ASSIGNMENT OF INSURANCE BENEFITS

I hereby certify that the following information given by me in applying for payment under the Titles XVIII and XIX of the Social Security Act or by any third-party payers is correct. I assign payment to Tampa Bay Breast Care Specialists of all benefits due me under the terms of said policies and programs. I assign payment to the Physician(s)/Healthcare Provider rendering medical services, the in hospital based Specialist, and the Physician(s)/Healthcare Provider for whom the hospital is authorized to bill in connection with its services. I understand that I am required to pay for any health insurance deductibles; coinsurance or any other charges incurred which are not paid by my insurance or other third-party payers together with all costs of collection, if necessary, including a reasonable attorney's fee if collected by or through an attorney at law.

RELEASE OF INFORMATION

I do hereby authorize Tampa Bay Breast Care Specialists and any physician/health care provider examining and/or treating me to release any medical information and records concerning diagnosis and treatment either during inpatient or outpatient treatment for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

FINANCIAL AGREEMENT

In consideration of medical treatment and services given to the patient, the undersigned unconditionally guarantees payment in full to Tampa Bay Breast Care Specialists (TBBCS) for all services rendered. Any uninsured portion of patient's account will remain payable when services are rendered. Any effort by TBBCS to collect insurance proceeds does not affect the responsibility of the patient and/or the undersigned guarantor, except to the extent TBBCS receives insurance proceeds. If TBBCS does not receive insurance proceeds within 60 days from billing, TBBCS will notify the patient and/or the guarantor who will be required to pay the balance in full. Should TBBCS find it necessary to refer this account to an attorney for collection to enforce the obligations of the patient and/or the undersigned the patient and/or the undersigned agrees to pay all collections expenses, including a reasonable attorney's fee. If a legal action is taken in connection with this agreement, the proper venue for such action shall be in Hillsborough County, Florida. All co-payments are required at time of service and appointment will be rescheduled if not paid.

HMO ELIGIBILITY GUARANTEE

I hereby certify that I am enrolled in an HMO and/or MediPass that I am receiving health care services authorized through the primary care physician that I have chosen or has been assigned to me or through my HMO plan. I understand that if the above is not true or if I am not eligible under the terms of my medical and hospital subscriber health insurance agreement, I am liable for all charges for the services rendered. Also, if the above is not true, I agree to pay in full for all services received within thirty (30) days of receiving a bill from Tampa Bay Breast Care Specialists. All HMO referral authorizations are the responsibility of the patient, and if proof of authorization has not been obtained and service has been rendered, patient accepts full responsibility of payment to TBBCS.

My signature represents that I have read the above and thereby give me agreement and authorization to all of the above:

_____ _____
(Signature) (Date)

_____
(Print Name)

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Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

- At Tampa Bay Breast Care Specialists' practice, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If we change any of the details of this notice, we will notify you of the changes in writing.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint; however, before filing a complaint, we recommend you seek more information regarding your health information privacy by contacting our Privacy Officer at 813-978-8315.

This notice is in effect as of April 14, 2003.

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Acknowledgement of Receipt for Notice of Privacy Practices

By signing this document, I acknowledge that I have received a copy of _____'s Notice of Privacy Practices.

_____ _____ _____
Name (Please print) Signature Date

If signing as a parent or guardian, please not the name of the patient _____

FOR INTERNAL OFFICE USE ONLY

Date Acknowledgement Received _____
or
Reason Acknowledgement was not obtained:

_____ _____ _____
Name (Please print) Signature Date

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION	
Patient's Name:	Today's Date:
Social Security #:	Date of Birth:

- I hereby authorize **Tampa Bay Breast Care Specialists** to ***release*** any information included in my chart to any medical practitioner, doctor, hospital, or medical institution to whom I may be referred to assist with my medical care.
- Additionally, I authorize **Tampa Bay Breast Care Specialists** to ***obtain*** any medical information from any medical practitioner, doctor, hospital, or medical institution to assist with my medical care.

Signature of Patient, Guardian, or Personal Representative	Date

Thank you for choosing Tampa Bay Breast Care Specialists!