



Janice Angeles, DO

Selyne Samuel, MD

Shelley Nakamura, MD

Noemi Sigalove, MD

Phone: 480.659.7384 • Fax: 480.247.8996

Phone: 480.278.8300
Fax: 623.223.1196

Phone: 480.699.2600
Fax: 480.393.8711

14674 W Mountain View Blvd
Suite 104
Surprise, AZ 85374

10320 W McDowell Rd
Building I, Suite 9030
Avondale, AZ 85392

19646 N 27th Ave #108
Phoenix, AZ 85027

7337 E 2nd St
Scottsdale, AZ 85251

3645 S Rome St #116
Gilbert, AZ 85297

Patient: _____
Last Name First MI Nickname

Patient Street/Mailing Address: _____ Unit/Apt #: _____

City, State: _____, _____ Zip Code: _____

Preferred Phone Contact: Home (_____) _____ - _____ Cell (_____) _____ - _____

Date of Birth: ____/____/____ Age: _____ Gender: F M Social Security #: _____

Email Address: _____

How do you want to receive your appointment reminders: Email By Phone

Mobile Phone Provider: _____

Preferred Language: English Spanish Other: _____

Do you have a Living Will? Yes No

Do you have a DNR (Do Not Resuscitate Order)? Yes No

Referred for consultation by: _____

Primary Care Physician (if not the same as referring physician): _____

Marital Status: Single Married Divorced Widowed Partnered

Race: _____ Ethnicity: _____

Patient Employer: _____ Business Phone: (_____) _____ - _____

Emergency Contact Name: _____

Relationship: _____ Phone: (_____) _____ - _____

(PLEASE INDICATE IF YOU HAVE MEDICARE INSURANCE)

Primary Insurance: _____ Subscriber Name: _____

Relationship to Subscriber: _____ Subscriber Date of Birth: ____/____/____

ID# _____ Group#: _____

Secondary Insurance: _____ Subscriber Name: _____

Relationship to Subscriber: _____ Subscriber Date of Birth: ____/____/____

ID# _____ Group#: _____

Pharmacy Name (Local, No Mail Order): _____

Phone Number: _____ Cross Streets: _____

Permission to access pharmacy records? Yes _____ No



Notice of Privacy Practices and Communication Consent

This form is to identify who may or may not have access to oral communication in regards to the patients protected health information while the patient is under treatment.

List the full name of family or friends that Comprehensive Breast Center of Arizona can share your protected health information.

Name	Phone Number	Relationship

Patient Home Phone: _____ Cell Phone: _____

May we leave a message? Yes No Please select preference for voice message: Home Cell phone.

Please list Physicians to receive correspondences from our office

Physician: _____ Specialty: _____
 Phone: (____) _____ - _____ Fax: (____) _____ - _____
 Address: _____
Street *City* *State* *Zip*

Physician: _____ Specialty: _____
 Phone: (____) _____ - _____ Fax: (____) _____ - _____
 Address: _____
Street *City* *State* *Zip*

Physician: _____ Specialty: _____
 Phone: (____) _____ - _____ Fax: (____) _____ - _____
 Address: _____
Street *City* *State* *Zip*

I, _____, acknowledge that I have received a copy of Comprehensive Breast Center of Arizona
Patient Name (please print)

Notice of Privacy Practices. I have identified who may or may not have access to my protected health information while under treatment at Comprehensive Breast Center of Arizona. I understand that this release is valid for the time frame of my diagnosis, but may revoke authorization at any time by informing Comprehensive Breast Center of Arizona and my physician.

Patient Signature: _____ Date: _____

Breast Care Center – Medical History Form

Name: _____

Date of Birth: _____

Reason for Today's Visit: _____

Please list your CURRENT MEDICATIONS/VITAMINS/SUPPLEMENTS	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Please list your ALLERGIES TO MEDICATIONS			
<input type="checkbox"/> No Known Allergies	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Codeine
	<input type="checkbox"/> Latex	<input type="checkbox"/> Iodine	<input type="checkbox"/> Adhesive
Others: _____			

Past Medical History			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Acid Reflux of Stomach (GERD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Back Disc
<input type="checkbox"/> Yes <input type="checkbox"/> No	Acute Myocardial Infarction (Heart Attack)	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol or High Lipids
<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension (High Blood Pressure)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis of the Liver
<input type="checkbox"/> Yes <input type="checkbox"/> No	Atrial Fibrillation, Palpitations (Irregular Heartbeat)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypothyroidism (Low Thyroid)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Autoimmune Disease, Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive
<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Dyscrasias (Blood Clotting Disorder)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Failure
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer, Breast	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Stones
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer, Ovarian	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer, Other Type: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obesity
<input type="checkbox"/> Yes <input type="checkbox"/> No	Carotid Stenosis (Blockage in Neck)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiomyopathy (Enlarged Heart)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cirrhosis of the Liver	<input type="checkbox"/> Yes <input type="checkbox"/> No	Peripheral Artery Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No	Congestive Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Insufficiency (Kidney Disease)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Deep Vein Thrombosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Heart Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea
<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema, COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you, or are you taking blood thinners ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Medical Problem: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Medical Problem: _____

Breast Care Center – Medical History Form

Name: _____

Date of Birth: _____

Surgical History			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Appendectomy (Appendix Removed)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cholecystectomy (Gallbladder Removal)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Aortic/Mitral Heart Valve Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Coronary Artery Bypass Graft/Cardiac Stents
<input type="checkbox"/> Yes <input type="checkbox"/> No	Aortobifemoral Bypass	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hysterectomy, One or Both Ovaries Left In
<input type="checkbox"/> Yes <input type="checkbox"/> No	Bladder Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hysterectomy, Both Ovaries Removed
<input type="checkbox"/> Yes <input type="checkbox"/> No	Brain Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Resection
<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast Biopsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nephrectomy (Kidney Removal)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast Lumpectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker, Cardiac
<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast Implant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Total Joint Replacement, Type: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast Mastectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Transplant (Kidney, Heart, or Lung)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast Reduction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Surgery Type: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Carotid Endarterectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Surgery Type: _____

Family History			
Maternal Side	<i>(Age at Diagnosis)</i>	Paternal Side	<i>(Age at Diagnosis)</i>
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Father	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Grandmother	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Grandmother	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Great-Grandmother	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Great-Grandmother	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Aunt/Uncle	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Aunt/Uncle	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Cousin	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Cousin	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Who in your family has had ovarian cancer? Please list age of diagnosis, alive or deceased. (e.g. Mother, Maternal Aunt, Paternal Grandmother)			
Who in your family has had other cancer types? Please list age of diagnosis, alive or deceased. (e.g. Mother, Maternal Aunt, Paternal Grandmother)			
Are you Ashkenazi Jewish? (We ask due to this subgroup having a high incidence of breast cancer)		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Breast Care Center – Medical History Form

Name: _____

Date of Birth: _____

Please indicate if you are CURRENTLY experiencing any of the following			
General/Constitutional		Gastrointestinal	
Bone Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abdominal Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No
New Onset Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Night Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Exposure to Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory		Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood In Sputum	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hematology	
Shortness of Breath at Rest	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easy Bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of Breath with Exertion	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prolonged Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast		Recent Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bloody Nipple Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurologic	
Breast Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Balance Difficulty	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nipple Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Red Skin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tingling/Numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiovascular		Ophthalmic	
Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling in Legs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Musculoskeletal	
Chest Pain at Rest	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Pain or Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain with Exertion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Restricted Motion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric	
Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin		Suicidal Ideation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Breast Care Center – Medical History Form

Name: _____

Date of Birth: _____

OB/GYN History	
How old were you when you had your first menstrual cycle?	
How old were you when you experienced menopause?	
How many pregnancies have you had?	
Number of births?	
How old were you when you had your first child?	
If you have taken oral contraceptives, how many years did you take them?	
If you have taken fertility treatments, how many years did you take them?	
If you have taken hormone replacement therapy medication (e.g. estrogen), how many years did you take them?	

Social History	
Do you consume alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, how many ounces per day?
Do you consume caffeine daily? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, how much per day?
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, how many packs per day?
Are you a former smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, how long did you smoke? If Yes, when did you quit? Date: _____



Financial Policy

Janice Angeles DO • Shelley Nakamura MD
Selyne Samuel, MD • Noemi Sigalove, MD

Thank you for choosing Comprehensive Breast Center of Arizona to meet your specialized medical needs. We are committed to providing you with the best treatment available. Please understand that payment of your bill is considered part of your treatment. All new patients must complete and sign the Patient Registration and our Financial Policy forms before seeing the physician.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE.

WE ACCEPT CASH, CHECK, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS.

PAYMENT PLANS ARE ACCEPTED UPON APPROVAL.

Regarding Insurance: Your insurance policy is a contract between you and your insurance company. We are not party to that contract. We will bill your insurance plan for you, as long as you provide us with correct information. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered medically necessary under your health insurance plan. You, as the patient, are ultimately responsible for payment of all services provided by Comprehensive Breast Center of Arizona. While payment is your responsibility, we will assist you in negotiating settlement with your insurance company for any disputed claim. Our billing department is available to discuss any questions you may have regarding your insurance or your account at 623-295-4554

Regarding insurance plans where we are a participating or preferred provider: All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating or preferred providers refer to the above paragraph. If you have a secondary insurance, we will bill it for you, as a courtesy, as long as you have provided us with the appropriate information.

Usual and Customary: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Medically Necessary Care: We will only provide you with a service if we consider it medically necessary. Therefore, if your insurance company arbitrarily determines that a service we have rendered to you is unnecessary, you will be responsible for the bill.

Credit Policy: Accounts are due and payable as of the date billed. Unpaid balances will be considered delinquent after 60 days.

We realize it may be necessary on occasion to arrange installment or other payment programs. If financial problems arise, please contact our billing department as soon as possible by calling 623-295-4554.

If an account becomes past due with no valid reason, necessary action will be taken to recover the account balance due. If your account is placed with an outside collection agency, you will be responsible for all collection fees and all legal fees.

No Show Appointments: Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, CBCA reserves the right to charge a fee of \$50 for all missed appointments ("no shows") and appointments not cancelled by 2:00 pm the day prior to your scheduled appointment. To cancel a *Monday* appointment, please call our office by 2:00 pm on *Friday*. If prior notification is not given you will be charged \$50 for the missed appointment. "No Show" fees are not covered by insurance and must be paid prior to your next appointment. If not paid, it will be charged to the card on file.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Patient Signature: _____

Date: _____



Patient Rights and Responsibilities

Every patient has the right to:

- ❖ Be treated with dignity and respect.
- ❖ Privacy and confidentiality concerning medical care.
- ❖ Be advised as to the reason for the presence of any individual directly involved or observing their care.
- ❖ Have questions, concerns, or complaints addressed in good faith.
- ❖ Be provided with complete information about diagnosis, indications for tests/procedures, treatment/alternatives, prognosis, and normal/abnormal test results in a timely manner.
- ❖ Make decisions regarding medical care to the extent permitted by law, including right to refuse treatment.
- ❖ Change physicians if other qualified physicians are available.
- ❖ Receive, on request, information about fees and charges, explanation of bill, regardless of source of payment.
- ❖ Have an advanced directive concerning treatment and designation of a surrogate decision maker.
- ❖ Exercise these rights without regard to gender, cultural, economic, educational or religious background.
- ❖ Have access to interpreter services, free of charge to the patient.

The patient has the responsibility to:

- ❖ Provide accurate & complete information concerning present complaints, past medical history, and other matters relating to his/her health.
- ❖ Make it known whether he/she clearly comprehends the course of treatment and what is expected of him/her.
- ❖ Follow the treatment plan established by his/her physician, including the instructions of nurses and other health care professionals, as they carry out the physician's orders.
- ❖ Keep appointments and notify Comprehensive Breast Center of Arizona (CBCA) or physician when unable to do so.
- ❖ Accept responsibility of his/her actions should he/her refuse treatment or not follow physician's orders.
- ❖ Assure that financial obligations of his/her care are fulfilled as promptly as possible.
- ❖ Follow CBCA policies and procedures.
- ❖ Be considerate of the rights and property of other patients and facility personnel.
- ❖ Notify CBCA staff of request for interpreter services.

If you have any comments or concerns regarding services provided by CBCA, please contact our practice administrator at (480) 659-7384 or write our practice administrator, 8283 N Hayden Rd, Ste 155, Scottsdale, AZ 85258.



Janice Angeles DO • Shelley Nakamura MD

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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

Protected health information, about you, is obtained as a record of your contacts or visits for healthcare services with Comprehensive Breast Center of Arizona. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services. Comprehensive Breast Center of Arizona is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law. If you have any questions about this notice please contact our Privacy Manager at 480-659-7384.

Your Rights Under The Privacy Rule: Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

You have the right to receive and we are required to provide you with a copy of this Notice Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

You have the right to authorize other use and disclosure - This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to designate a personal representative - This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

You have the right to inspect and copy your protected health information - This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record.

You have the right to request a restriction of your protected health information - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases we may deny your request for a restriction.

You may have the right to have us amend your protected health information - This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have the right to request a disclosure accountability - This means that you may request a listing of your protected health information disclosures we have made to entities or persons outside of our office.

Complaints: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Manager of your complaint.

How We May Use or Disclose Protected Health Information: Following are examples of use and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but do describe the types of uses and disclosures that may be made by our office.

For Treatment - We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results for exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. And, we may contact you to provide information about health related benefits and services offered by our office.

For Payment - Your protected health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for

you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations - We may use or disclose, as needed, your protected health information in order to support the business activities of our practices. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes Education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identification information.

Other Permitted and Required Uses and Disclosures: We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, **that you identify**, your protected health information that directly relates to that person's involvement in your health care. If you are to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required by Law - We may use or disclose your protected health information to the extent that the use or disclosure is required by law.

For Public Health - We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

For Communicable Diseases - We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

For Health Oversight - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Case of Abuse or Neglect - We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

To The Food and Drug Administration - We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products: to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required.

For Legal Proceedings - We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

To Law Enforcement - we may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

To Coroners, Funeral Directors, and Organ Donation - We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

In Cases of Criminal Activity - consistent with applicable federal and state laws, we may disclose protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

For Military Activity and National Security - When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities: (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or: (3) to foreign military authority if you are a member of that foreign military services.

For Worker's Compensation - Your protected health information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally-established programs.

When an Inmate - We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures - Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.



Authorization to Use, Disclose, and Request Protected Health Information

There are times when Comprehensive Breast Center of Arizona (CBCA) will need to request reports and health information from your other physicians and/or medical centers for your care at CBCA. We also keep your other physicians notified of your treatment outcomes by sending all treatment reports and information to their facilities. In order to do so, your authorization is required.

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I authorize the use, request and/or disclosure of my protected health information as described below. I understand that the information used or disclosed as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or disclosed to persons or organizations receiving it without obtaining my authorization. I have the right to revoke this Authorization by providing written notice to Comprehensive Breast Center of Arizona. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

Comprehensive Breast Center of Arizona (Circle your location)

Avondale 10320 W McDowell Rd Building I, Suite 9030 Avondale, AZ 85392 Phone: 480.659.7384 Fax: 480.247.8996	Phoenix 19646 N 27 th Ave #108 Phoenix, AZ 85027 Phone: 480.278.8300 Fax: 623.223.1196	Surprise 14674 W Mountain View Blvd Suite 140 Surprise, AZ 85374 Phone: 480.659.7384 Fax: 480.247.8996	Osborn 7337 E 2 nd St Scottsdale, AZ 85251 Phone: 480.699.2600 Fax: 480.393.8711	Gilbert 3645 S Rome St #116 Gilbert, AZ 85297 Phone: 480.699.2600 Fax: 480.393.8711
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I understand that this release is valid for the timeframe of my diagnosis through treatment, but I may revoke this authorization at any time by informing CBCA and my physician.

Health information to release includes the following (as checked):

- Entire Health Record including consultation and follow-up notes, radiology results, physics/dosimetry data, and complete treatment record
- Records from outside physicians that are sent to a physician at CBCA
- I give special permission to release any information regarding: (Initial on applicable line(s) only)
 - _____ Substance Abuse _____ Genetic Testing _____ HIV Information

Purpose: (Check applicable categories)

- Further Medical Care
- Patient's Request
- Insurance Eligibility/Benefits
- Disability Determination
- Legal Investigation
- Other: _____

Records to be released from or to (Office Use ONLY)

Clinic Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Expiration Date and Other Information:

This authorization will expire after the completion of my treatment at Comprehensive Breast Center of Arizona. A photocopy of this authorization is as valid as the original. I understand this authorization is voluntary. I am confirming my authorization that the health care provider may use, request and/or disclose to the persons and/or organizations named in this form the protected health information described above. I understand that no person or entity authorized to use, disclose or request health care information may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Patient Signature

Date