AZCCC
Arizona Center for Cancer Care

Acknowledgment of Receipt of Privacy
Notice and Patient Rights and Responsibilities

I acknowledge that I have received a copy of the office's Notice of Privacy Practices and Patient Rights and Responsibilities.

_____	_____
Patient or legally authorized individual signature	Date
_____	_____
Printed Name if signed on behalf of the patient	Relationship to Patient

Consent for Treatment/Care

I consent to treatment and care by Comprehensive Breast Center of Arizona and by their physicians and health care providers, including those who are located at sites other than the one at which I am present and who provide treatment and care through electronic communications. I understand that my treatment and care may include routine care, such as assessments, medications, and a variety of other medical services depending on my condition, such as laboratory testing. I can receive a list of services and care from my health care provider. I understand that my care team at Comprehensive Breast Center of Arizona may include resident physicians and students or other trainees. I am aware that the practice of medicine (including surgery) is not an exact science, and no one has made any guarantees about the results of my treatments, payments, examinations, or procedures.

Date:_____

Patient name (printed):_____

Patient Signature:_____

Notice of Privacy Practices for Protected Health Information

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

This office is required by a federal regulation, known as the HIPAA Privacy Rule, to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. This office will not use or disclose your health information except as described in this Notice.

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. The health information about you is documented in a medical record and on a computer. Such information may include documenting your symptoms, medical history, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are: A health professional obtains treatment information about you and records it in a health record. During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input. **Example of use of your health information for payment purposes:** We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests health information from us regarding medical care given. We will provide information to them about you and the care given, which may include copies or excerpts of your medical record which are necessary for payment of your account. For example, a bill sent to your health insurance company may include information that identifies your diagnosis, and the procedures and supplies used. **Your Health Information Rights** The health and billing records we maintain are the physical property of the doctor's office. The information in it, however, belongs to you. You have a right to: Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office—we are not required to grant the request but we will comply with any request granted; Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office; Request that you be allowed to inspect and copy your medical record and billing record—you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request; Appeal a denial of access to your protected health information except in certain circumstances; Request that your medical record be amended to correct incomplete or incorrect information by delivering a written request, including a reason to support it, to our office using the form we provide to you upon request. (We are not required to make such amendments); File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information; Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include uses and disclosures of information for treatment, payment, or health care operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; or to family members or friends or uses relevant to that person's involvement in your care or in payment for such care; or uses or disclosures to notify family or others responsible for your care of your location, condition, or your death; we may charge a cost-based fee for more than one accounting in a 12-month period. Request that confidential communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we provide to you upon request; and, Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office. If you want to exercise any of the above rights, please contact Laura Mikkelson, 602-942-8000, 2525 W. Greenway Road, Suite 130, Phoenix, AZ 85023, in person or in writing, during normal business hours. Our Privacy Officer will provide you with assistance on the steps to take to exercise your rights. You have the right to review this Notice before signing the acknowledgment authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

Our Responsibilities The office is required to: Maintain the privacy of your health information as required by law; Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you; Abide by the terms of this Notice; Notify you if we cannot accommodate a requested restriction or request; and Accommodate your reasonable requests regarding methods to communicate health information with you. We will not disclose any confidential communicable disease-related information about an individual except in situations where the subject of the information has provided us with a written authorization allowing the release or where we are authorized or required by state or federal law to make the disclosure. We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint If you have questions, would like additional information, want to report a problem regarding the handling of your information, of if you believe your privacy rights have been violated and wish to file a written complaint with our office, please contact Laura Mikkelson, 602-942-8000, 2525 W. Greenway Road, Suite 130, Phoenix, AZ 85023. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services. We cannot, and will not, require you to waive your rights under the Privacy Rule including the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

PATIENT COPY

Other Disclosures and Uses We Can Make Without Your Written Authorization **Notification of Family/Friends** Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death. **Communication with Family/Friends** Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency. **Disaster Relief** We may use and disclose your health information to assist in disaster relief efforts. **Employers** We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute an authorization for the release of that information to your employer. **Deceased Persons** We may disclose your health information to funeral directors, medical examiners, or coroners consistent with applicable law to allow them to carry out their duties. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties. **Organ Procurement Organizations** Consistent with applicable law, we may disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant. **Appointment Reminders, Marketing and Treatment Alternatives** We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you. We may also encourage you to purchase a product or service when we see you. We will not disclose your health information without your written authorization. **Food and Drug Administration (FDA)** We may disclose to the FDA your health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements. **Workers' Compensation** If you are seeking compensation through Workers' Compensation, we may disclose your health information to the extent necessary to comply with laws relating to Workers' Compensation. **Public Health** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition. **Abuse, Neglect & Domestic Violence** We may disclose your health information to public authorities as allowed by law to report abuse, neglect, or domestic violence. **Sign in Sheet** We may use and disclose your health information by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you. **Inmates** If you are an inmate of a correctional institution or under the custody of a law enforcement officer, we may disclose to the institution or law enforcement official health information necessary for your health and the health and safety of other individuals. **Law Enforcement** We may disclose your health information for law enforcement purposes as required by law, such as when required by a court order; for identification of a victim of a crime if certain protective requirements are met; to report a crime on our premises; to report crime in emergencies; and other appropriate situations permitted by law. **Health Oversight** We may disclose your health information to appropriate health oversight agencies or for health oversight activities. **Judicial/Administrative Proceedings** We may disclose your health information in the course of any judicial or administrative proceeding as allowed or required by law or as directed by a proper court order or in response to a subpoena, with your authorization, discovery request or other lawful process if certain specific requirements are met. **Serious Threat** To avert a serious threat to health or safety, we may disclose your health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public. **For Specialized Governmental Functions** We may disclose your health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel. **Other Uses** Other uses and disclosures of your health information besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided in this Notice. **Website** If we maintain a website that provides information about our office, this Notice will be on the website. **Research** We may disclose your health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Original Effective Date: April 14, 2003

COMPREHENSIVE BREAST CENTER OF AZ
LISE C. WALKER, M.D. AND VICTOR J. ZANNIS, M.D.
2525 W. GREENWAY ROAD, SUITE 130
PHOENIX, AZ 85023
PHONE (602) 942-8000 FAX (602) 942-8025

Patient_____
Last name, First MI Nickname

Referring physician and other physicians _____

Patient Street/Mailing Address_____Apt/Unit#_____

City, State_____, _____ **ZIP**_____ Preferred Phone Contact:
Home Phone (10 digit) (____)_____
Cell Phone (10 digit) (____)_____

Birthdate:__/__/__ Age__ Social Sec#_____
E-mail address_____

Single__ Married__ Divorced__ Widow__ Partnered__ Race_____ Ethnicity_____
Patient Employed By_____ Business Phone (_____)_____

Spouse Name_____ Birthdate____/____/____
Spouse's Employer Name_____ Business/Cell Phone (____)_____
(or Emergency Contact Name & Phone)

(PLEASE INDICATE IF YOU HAVE MEDICARE INSURANCE!)
Name of Primary Insurance_____ Name of Insured_____
Relationship to Patient_____ Group #_____ ID# or SSN:_____

Names of Secondary Insurance_____ Name of Insured_____
Relationship to Patient_____ Group #_____ ID# or SSN:_____

Pharmacy Phone/Name/Location_____

Assignment and Release: I agree that this office may release my records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physicians participation with my health plan. I authorize my insurance benefits to be paid directly to my physician and I realize that I am financially responsible for any non-covered services or expenses.

____Please initial if OK to use this form for release to request records not provided for today's consultation.

_____
Signature Date

I acknowledge that I have received a copy of the office's Notice of Privacy Practices. _____
Signature

_____ _____
Printed name if signed on behalf of patient Relationship (parent, legal guardian, personal representative, etc.)

Do you have an Advance Directive? Y N (Please provide if available)

FOUR more pages to go

Breast Care Center – Medical History Form

Name: _____ Date of Birth: _____

Current Medications (Names Only)	
1._____	7._____
2._____	8._____
3._____	9._____
4._____	10._____
5._____	11._____
6._____	12._____

Past Medical History (Fill in circle if you have history of this)			
Acid Reflux of Stomach (GERD)	O	High Cholesterol or High Lipids	O
Acute Myocardial Infarction (Heart Attack)	O	Hypertension (High Blood Pressure)	O
Anemia	O	Hepatitis of the Liver	O
Arthritis	O	Hyperthyroidism (High Thyroid)	O
Asthma	O	Hypothyroidism (Low Thyroid)	O
Irregular Heartbeat	O	HIV Positive	O
Autoimmune Disease	O	Kidney Failure	O
Blood Dyscrasias (Blood Clotting Disorder)	O	Kidney Stones	O
Cancer, Breast	O	Multiple Sclerosis	O
Cancer, Ovarian	O	Obesity	O
Cancer, Other Type:_____	O	Osteoporosis	O
Carotid Stenosis (Blockage In Neck)	O	Parkinsons Disease	O
Cardiomyopathy (Enlarged Heart)	O	Peripheral Artery Disease	O
Cirrhosis of the Liver	O	Renal Insufficiency (Kidney Disease)	O
Congestive Heart Failure	O	Rheumatic Heart Disease	O
Deep Vein Thrombosis	O	Sleep Apnea	O
Diabetes	O	Seizures	O
Emphysema, COPD	O	Other Medical Problem: Type:_____	O
Heart Murmur	O	Other Medical Problem: Type:_____	O
Herniated Back Disc	O		

Breast Care Center – Medical History Form

Name: _____ Date of Birth: _____

Allergies to Medications
____No Known Allergies ____ Penicillin ____Sulfa ____Codeine
Other medication allergies: 1._____ 2._____ 3._____

Surgical History			
Appendectomy (Appendix Removed)	O	Cholecystectomy (Gallbladder Removal)	O
Aortic/Mitral Heart Valve Replacement	O	Coronary Artery Bypass Graft/Cardiac Stents	O
Aortobifemoral Bypass	O	Hysterectomy, One or Both Ovaries Left In	O
Bladder Surgery	O	Hysterectomy, Both Ovaries Removed	O
Brain Surgery	O	Lung Resection	O
Breast Biopsy	O	Nephrectomy (Kidney Removed)	O
Breast Lumpectomy	O	Pacemaker, Cardiac	O
Breast Implant	O	Total Joint Replacement Type:_____	O
Breast Mastectomy	O	Transplant (Kidney, Heart, or Lung)	O
Breast Reconstruction	O	Other Surgery Type:_____	O
Carotid Endarterectomy	O	Other Surgery Type:_____	O

Family History	
Who in your family has had breast cancer? (e.g, mother, maternal aunt, paternal grandmother)	
Who in your family has had ovarian cancer?	
Are you Ashkenazi Jewish? (We ask since this subgroup has higher incidence of breast cancer.)	O Yes O No

Social History	
How much alcohol do you consume a week?	
Do you smoke? O Yes O No Former smoker? O Yes O No	

Breast Care Center – Medical History Form

Name: _____ Date of Birth: _____

General/Constitutional	
Bone Pain	O
Fatigue	O
Fever	O
New Onset Headache	O
Night Sweats	O
Ophthalmic	
Blurred Vision	O
Respiratory	
Blood In Sputum	O
Cough	O
Shortness Of Breath At Rest	O
Shortness Of Breath With Exertion	O
Wheezing	O
Breast	
Bloody Nipple Discharge	O
Breast Lump	O
Breast Pain	O
Breast Swelling	O
Nipple Discharge	O
Red Skin	O
Nipple Retraction	O
Cardiovascular	
Heart Attack	O
Heart Murmur	O
Swelling In Legs	O
Chest Pain At Rest	O
Chest Pain With Exertion	O
Dizziness	O
Irregular Heartbeat	O
Palpitations	O
Weakness	O

Gastrointestinal	
Jaundice	O
Abdominal Pain	O
Constipation	O
Diarrhea	O
Exposure to Hepatitis	O
Nausea	O
Vomiting	O
Hematology	
Easy Bruising	O
HIV	O
Prolonged Bleeding	O
Recent Transfusion	O
Swollen Glands	O
Skin	
Rash	O
Neurologic	
Balance Difficulty	O
Difficulty Speaking	O
Fainting	O
Seizures	O
Tingling/Numbness	O

ONE more page to go

Name: _____ Date of Birth: _____

OB / GYN History	
How old were you when you started your period?	
How old were you when you experienced menopause?	
How many pregnancies have you had?	
How many 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 medications (e.g.,estrogen), how many years did you take them?	