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			
❑ No Known Allergies	❑ Penicillin Reaction: ______________	❑ Sulfa Reaction: ______________	❑ Codeine Reaction: ______________
	❑ Latex Reaction: ______________	❑ Iodine Reaction: ______________	❑ Adhesive Reaction: ______________
Other allergies with reactions:			

Past Medical History

❑ Yes ❑ No	Acid Reflux of Stomach (GERD)	❑ Yes ❑ No	Heart Disease
❑ Yes ❑ No	Acute Myocardial Infarction (Heart Attack)	❑ Yes ❑ No	High Cholesterol or High Lipids
❑ Yes ❑ No	Anemia	❑ Yes ❑ No	Hypertension (High Blood Pressure)
❑ Yes ❑ No	Asthma	❑ Yes ❑ No	Hypothyroidism (Low Thyroid)
❑ Yes ❑ No	Atrial Fibrillation	❑ Yes ❑ No	Kidney Disease
❑ Yes ❑ No	Autoimmune Disease Type: ________________________	❑ Yes ❑ No	Obesity
❑ Yes ❑ No	Blood Dyscrasias (Blood Clotting Disorder) Type: ________________________	❑ Yes ❑ No	Osteoporosis
❑ Yes ❑ No	Cancer, Breast	❑ Yes ❑ No	Parkinson's Disease
❑ Yes ❑ No	Cancer, Other Type: ________________________	❑ Yes ❑ No	Sleep Apnea
❑ Yes ❑ No	COPD	❑ Yes ❑ No	Seizures
❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Transient ischemic attack (stroke)
❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	Other Medical Problem(s): ____________________________

Surgical History

❑ Yes ❑ No	Appendectomy (Appendix Removed)		Date: ____________________
❑ Yes ❑ No	Bladder Surgery		Date: ____________________
❑ Yes ❑ No	Brain Surgery		Date: ____________________
❑ Yes ❑ No	Breast Biopsy	❑Left side Date: ____________________	❑Right side Date:____________________
❑ Yes ❑ No	Breast Lumpectomy	❑Left side Date:____________________	❑Right side Date:____________________
❑ Yes ❑ No	Breast Mastectomy	❑Left side Date:____________________	❑Right side Date:____________________
❑ Yes ❑ No	Breast Augmentation		Date: ____________________
❑ Yes ❑ No	Breast Reduction		Date: ____________________
❑ Yes ❑ No	Carotid Endarterectomy		Date: ____________________
❑ Yes ❑ No	Cesarean Section		Date: ____________________
❑ Yes ❑ No	Cholecystectomy (Gallbladder Removal)		Date: ____________________
❑ Yes ❑ No	Cataract removal		Date: ____________________
❑ Yes ❑ No	Dental surgery		Date: ____________________
❑ Yes ❑ No	Heart surgery		Date: ____________________
❑ Yes ❑ No	Hysterectomy with both ovaries left in		Date: ____________________
❑ Yes ❑ No	Hysterectomy with both ovaries removed		Date: ____________________
❑ Yes ❑ No	Hysterectomy with one ovary removed Side of removal: ❑Left ❑Right		Date: ____________________
❑ Yes ❑ No	Nephrectomy (Kidney Removal)		Date: ____________________
❑ Yes ❑ No	Tonsillectomy		Date: ____________________
❑ Yes ❑ No	Total Joint Replacement Type: ______________________________________ Side of replacement: ❑Left ❑Right		Date: ____________________
❑ Yes ❑ No	Transplant (Kidney, Heart, Lung, Liver, etc.) Side of transplant (if applicable): ❑Left ❑Right		Date: ____________________
❑ Yes ❑ No	Other Surgery Type: ______________________________________		Date: ____________________
❑ Yes ❑ No	Other Surgery Type: ______________________________________		Date: ____________________

Family History of Cancer

Family Member	Affected	Maternal/ Paternal	Type of cancer	Age of diagnosis	Current age if Living/deceased
Mother	❑ Yes ❑ No	N/A			
Father	❑ Yes ❑ No	N/A			
Daughter	❑ Yes ❑ No	N/A			
Son	❑ Yes ❑ No	N/A			
Sister	❑ Yes ❑ No				
Brother	❑ Yes ❑ No				
Grandmother	❑ Yes ❑ No				
Grandfather	❑ Yes ❑ No				
Aunt	❑ Yes ❑ No				
Uncle	❑ Yes ❑ No				
Cousin	❑ Yes ❑ No				
Other: ________________	❑ Yes ❑ No				
Are you Ashkenazi Jewish? (We ask due to this subgroup having a high incidence of breast cancer)					❑ Yes ❑ No

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?			
Have you taken oral contraceptives?	❑ Yes ❑ No	If yes, how long? _______________	Currently taking? ❑ Yes ❑ No
Have you taken fertility treatments?	❑ Yes ❑ No	If yes, how long? _______________	Currently taking? ❑ Yes ❑ No
Have you taken hormone replacement therapy medication?	❑ Yes ❑ No	If yes, how long? _______________	Currently taking? ❑ Yes ❑ No

Social History

Do you consume alcohol?	❑ Yes ❑ No	If Yes, how many ounces per day?
Do you consume caffeine daily?	❑ Yes ❑ No	If Yes, how much per day?
Do you smoke?	❑ Yes ❑ No	If Yes, how many packs per day?
Are you a former smoker?	❑ Yes ❑ No	If yes, how long did you smoke? If yes, when did you quit? Date: _____________________

Please indicate if you are CURRENTLY experiencing any of the following

General/Constitutional	
Bone Pain	❑ Yes ❑ No
Fatigue	❑ Yes ❑ No
Fever	❑ Yes ❑ No
New Onset Headache	❑ Yes ❑ No
Night Sweats	❑ Yes ❑ No

Respiratory	
Blood In Sputum	❑ Yes ❑ No
Cough	❑ Yes ❑ No
Shortness of Breath at Rest	❑ Yes ❑ No
Shortness of Breath with Exertion	❑ Yes ❑ No
Wheezing	❑ Yes ❑ No

Breast		If yes…
Bloody Nipple Discharge	❑ Yes ❑ No	❑ Left ❑ Right
Breast Lump	❑ Yes ❑ No	❑ Left ❑ Right
Breast Pain	❑ Yes ❑ No	❑ Left ❑ Right
Breast Swelling	❑ Yes ❑ No	❑ Left ❑ Right
Nipple Discharge	❑ Yes ❑ No	❑ Left ❑ Right
Red Skin	❑ Yes ❑ No	❑ Left ❑ Right

Cardiovascular	
Heart Attack	❑ Yes ❑ No
Swelling in Legs	❑ Yes ❑ No
Chest Pain at Rest	❑ Yes ❑ No
Chest Pain with Exertion	❑ Yes ❑ No
Dizziness	❑ Yes ❑ No
Irregular Heartbeat	❑ Yes ❑ No
Palpitations	❑ Yes ❑ No
Weakness	❑ Yes ❑ No

Skin	
Rash	❑ Yes ❑ No

Gastrointestinal	
Jaundice	❑ Yes ❑ No
Abdominal Pain	❑ Yes ❑ No
Constipation	❑ Yes ❑ No
Diarrhea	❑ Yes ❑ No
Exposure to Hepatitis	❑ Yes ❑ No
Nausea	❑ Yes ❑ No
Vomiting	❑ Yes ❑ No

Hematology	
Easy Bruising	❑ Yes ❑ No
HIV	❑ Yes ❑ No
Prolonged Bleeding	❑ Yes ❑ No
Recent Transfusion	❑ Yes ❑ No
Swollen Glands	❑ Yes ❑ No

Neurologic	
Balance Difficulty	❑ Yes ❑ No
Fainting	❑ Yes ❑ No
Seizures	❑ Yes ❑ No
Tingling/Numbness	❑ Yes ❑ No

Ophthalmic	
Blurred Vision	❑ Yes ❑ No

Musculoskeletal	
Joint Pain or Swelling	❑ Yes ❑ No
Restricted Motion	❑ Yes ❑ No
Muscle Pain	❑ Yes ❑ No

Psychiatric	
Anxiety	❑ Yes ❑ No
Depression	❑ Yes ❑ No
Suicidal Ideation	❑ Yes ❑ No

Janice Angeles, DO **Selyne Samuel, MD**

Phone: 480.659.7384 • Fax: 480.393.7792

14674 W Mountain View Blvd
Suite 104
Surprise, AZ 85374

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

Shelley Nakamura, MD

Phone: 480.278.8300
Fax: 623.223.1196

19646 N 27th Ave #108
Phoenix, AZ 85027

Noemi Sigalove, MD

Phone: 480.699.2600
Fax: 480.393.8711

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 detailed 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:__________________________

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

<u>Every patient has the right to:</u>

- Be treated with dignity, respect, and consideration.
- Not be discriminated against base on race, age, gender, national origin, religion, sexual orientation, disability, marital status or diagnosis.
- To receive privacy in treatment and care for personal needs
- To receive treatment that supports and respects your individuality, choices, strengths and abilities
- Not be subjected to misappropriation of personal and private property by your provider or its staff
- To review upon written request, your medical record
- Safe care and not be subjected to neglect, exploitation, coercion, manipulation, abuse (physical, sexual, emotional) or sexual assault.
- Know the identity of those professionals that are treating you.
- Participate or have your representative participate in the development of, or decisions concerning, treatment
- To receive a referral to another provider if our clinic cannot provide services needed
- Refuse or withdraw treatment to the extent permitted by law including research or experimental treatment.
- Receive explanation prior to any transfer of care.
- Have assistance from a family member, representative or other individual in understanding, protecting, or exercising your rights.
- File a complaint with a manager, the Department of Health Services, or your provider without retaliation
- Understand why someone is involved or observing care
- Not be restrained or secluded.
- Receive, on request, information about schedule of rates, charges, explanation of bill, regardless of source of payment.
- Consent to photographs before one is taken, except for photos taken for identification / administrative purposes
- Have an advanced directive concerning treatment.
- Except in an emergency, provide you with alternative to a proposed psychotropic medication or surgical procedures along with any associated risks and possible complications of the proposed treatment.

<u>The patient has the responsibility to:</u>

- Provide accurate & complete information concerning present complaints, past
- Medical history, and other matters relating to his/her health.
- Make it known whether you clearly comprehend 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, notify Arizona Center for Cancer Care or physician when unable to do so.
- Accept responsibility of your actions should you refuse treatment or not follow physician’s orders.
- Assure that financial obligations of your care are fulfilled as promptly as possible.
- Follow AZCCC policies and procedures.
- Be considerate of the rights and property of other patients and facility personnel.
- Notify the AZCCC 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, 9055 E Del Camino Dr, Ste 200, Scottsdale, AZ 85260.

Janice Angeles DO • Shelley Nakamura MD

Selyne Samuel, MD • Noemi Sigalove, MD

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.

<u>Other Permitted and Required Uses and Disclosures:</u> 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, **<u>that you identify</u>**, 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.

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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Patient Rights and Responsibilities and Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Patient Signature:____ Date:____________________

CONSENT TO BE TREATED BY:
Comprehensive Breast Center of Arizona

Consent for Treatment:

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.

I acknowledge that I have read the Consent for Treatment, and that I am agreeing to its explanation.

Patient Signature:____ Date:____________________

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	Phoenix	Surprise	Osborn	Gilbert
10320 W McDowell Rd Building I, Suite 9030 Avondale, AZ 85392 Phone: 480.659.7384 Fax: 480.393.7792	19646 N 27th Ave #108 Phoenix, AZ 85027 Phone: 480.278.8300 Fax: 623.223.1196	14674 W Mountain View Blvd Suite 140 Surprise, AZ 85374 Phone: 480.659.7384 Fax: 480.393.7792	7337 E 2nd St Scottsdale, AZ 85251 Phone: 480.699.2600 Fax: 480.393.8711	3645 S Rome St #116 Gilbert, AZ 85297 Phone: 480.699.2600 Fax: 480.393.8711

❑ 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: ______________________

<u>Records to be released from or to (*Office Use ONLY)*</u>

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

Advance Medical Directive Information

General Information

Every adult has the legal right to consent to or refuse medical treatment, and may declare their wishes in writing in the event that they cannot communicate them. All medical facilities that receive Medicare or Medicaid funds must tell their patients about these rights. Patients should make their wishes known in the event they become incapacitated. This can be very helpful to doctors and to family members. Most hospitals ask for any advance medical directives you may have, and many even provide a short form for you to make the decisions on the spot. However, you are not required to have any advance medical directives in order to receive care, treatment, or be admitted.

There are five primary types of advance medical directives: 1. Living Wills; 2. CPR Orders/Do Not Resuscitate Orders; 3. Medical/Health Care Power of Attorney; 4. Disposition of Last Remains Declarations; and 5. Organ and Tissue Donation Declarations. An advance medical directive document may incorporate several of these directives. Signing an advanced medical directive does not take away your right to make medical decisions if you are able to do so, but allows your beliefs and decisions to be carried out when you cannot communicate them.

If you do not execute any advance medical directives or appoint a person to make decisions for you and you become incapacitated, your loved ones may have to go to court and pursue a guardianship so they have the authority to make medical decisions for you. While you are encouraged to work with an attorney to execute advance medical directives, Living Will and Medical Power of Attorney forms are available at most office supply stores or by going to https://azsos.gov/services/advance-directives. If you choose to use a form, make sure it is an Arizona form as the requirements for advance medical directives are state specific. You should provide copies of your advance directives to your doctor, family members, health care agent, and any medical facility you may be admitted to.

So long as your Living Will and other advance medical directives comply with the state law where the directive is executed, it will likely be recognized and honored in all other states. Nevertheless, if you spend a significant amount of time in more than one state, such as having a vacation or winter home in another state, you should execute documents in both states in case there are different requirements. It is very important to make sure all your declarations are consistent to avoid any confusion or disputes.
You should keep the original directives somewhere that is easily accessible and you should inform your loved ones where to find them. It is not a good idea to place the documents in a safe deposit box at a bank, as on weekends, holidays, and nights, the documents would not be available for use.

Communication is key. Many people prefer to keep their legal affairs private, but when it comes to end of life and medical treatment issues, communication with family members, close friends, doctors, and other medical professionals is the key to ensuring your wishes are followed. Take the time to discuss these issues with your family, close friends, and medical professionals.