What to Expect and How to Prepare for the Mammography Screening

What to Expect

It takes approximately 10 minutes to perform a mammography. Each breast is compressed twice. You will experience a "pinching" sensation during compression.

How to Prepare

1. Wear a two-piece outfit.
2. DO NOT USE ANY POWDER, DEODORANT, LOTION OR PERFUME in the breast or armpit area.

**WE WILL NOT PERFORM A SCREENING MAMMOGRAM IF YOU HAVE IMPLANTS OR HAVE STOPPED NURSING FOR LESS THAN 6 MONTHS.**

What to Bring

Bring two envelopes: one addressed to yourself with your home address and one addressed with your ob-gyn doctor’s address. These will be the envelopes we will use to mail the reports. Also, bring your completed medical history form, a copy of the front and back of your insurance card with the insurance form to your appointment. DO NOT FAX THE FORM TO OUR OFFICE.

Please make every effort to obtain and bring your prior mammography films if you have not had a mammography with us in the past. They will be compared for subtle changes with your current films by our radiologist.

If your mammogram results indicate a need for additional testing, you will need to bring your films with you when you have the diagnostic follow up. We will send your original films to the diagnostic center or doctor you indicate. They will be sent by either "UPS" or "Federal Express" ground, receiving signature required.” Please remit $10.00 to cover the cost of the mailing. Checks can be made payable to Multi-Diagnostics and mailed to the address shown above or payment can be made by American Express, Mastercard, Visa or Discover Card.
PLEASE CIRCLE YOUR ANSWERS. PLEASE DO NOT LEAVE ANY UNANSWERED QUESTIONS

Past/Present Medications (If yes, state drug name and length of time used)

Birth Control Pills  NO  YES _____________________________  Age you began menstruating? ________________
Hormones  NO  YES _____________________________  Number of pregnancies? ________________
Thyroid  NO  YES _____________________________  Your age at first pregnancy? ________________

Have you started Menopause:  NO  YES  if yes:  NATURAL  SURGICAL  Age Began ______

Have you had...
A hysterectomy?  NO  YES  if yes, at what age? ______  An Ovary Removed?  NO  YES (Left, Right) Age? ______

Any Prior Breast Surgery?  When?  Which Breast?  Radiation Treatment?  Do you have any of the following NOW?
Mastectomy  NO  YES  ________  R L Both  NO  YES  Fibrocystic Disease  NO  YES
Lumpectomy  NO  YES  ________  R L Both  NO  YES  Breast Lumps  NO  YES  R L Both
Breast Biopsy  NO  YES  ________  R L Both  NO  YES  Tenderness  NO  YES  R L Both
Drainage of Cyst  NO  YES  ________  R L Both  NO  YES  Breast Pain  NO  YES  R L Both
Breast Implants  NO  YES  ________  R L Both  NO  YES  Skin Retraction  NO  YES  R L Both

Other ____________________________________  Nipple Discharge  NO  YES (Left, Right)
If yes, what color? _____________________

Are the above symptoms related to your period?  NO  YES  SOMETIMES

Family History of Breast Cancer?  (Please Circle)
Mother  NO  YES  Previous Mammogram?
Aunts  NO  YES  Mother's or Father's side?
Sisters  NO  YES  When? ________________
Grandmothers  NO  YES  Mother's or Father's side?
Daughters  NO  YES  Where? ________________
If Yes, at what age (approximately) was the person first diagnosed? ________________  Date of last Clinical Breast Exam? ________________

OVER  Technicians Signature ____________________________
PLEASE READ AND SIGN ACKNOWLEDGING ITEMS 1-4

1.1___________________________ hereby give my consent and permission to Multi- Diagnostic Services, Inc., its technicians and employees, to perform a visual and/or manual breast examination and/or mammography test on me. I also understand that a visual and/or manual breast examination and/or mammography do not constitute a complete examination for cancer, nor do they guarantee the absence of cancer if the results are negative.

I am solely responsible for following any recommendations made to me by the physician for any subsequent follow-up examinations, diagnostic studies, evaluations or treatments in the event that the results of the examination or mammogram are suspicious for malignancy, or there is any area of questionable abnormality found.

2.1 HEREBY DECLARE THAT TO THE BEST OF MY KNOWLEDGE I AM NOT PREGNANT AT THIS TIME AND/OR THAT I AM NOT NURSING A CHILD.

3.1 authorize Multi-Diagnostic Services, Inc. to receive any and all medical records and reports that pertain to my mammography findings. This includes, but is not limited to: ultrasound; spot, magnification, and any other additional views; biopsy results as well as previous mammography and sono films. This will enable Multi-Diagnostic Services, Inc. to update my medical chart as per Mammography Quality Standard Act (MQSA/HR6182).

4.1 understand that the results of my examination and mammography will be reported to my designated physician. If follow-up test(s) are necessary, I give my permission for Multi-Diagnostic Services, Inc. to release my mammography films to me, a person designated by me, a doctor or the facility doing the testing. If screened through the NY State DOH Breast Health Partnership Program your films will be sent to a participating partner facility for follow-up care and your medical/personal information will be released to the corresponding NY State Partnership office and the follow-up facility listed unless you tell us not to. Your refusal must be in writing.

If desired; please provide us with the name of a relative or friend authorized to have your mammogram results along with their address and phone number:
Name ____________________________Address/Phone

Signature _______________________________  Date

Witness

Your Physician Information

Name _____________________________ ______Phone Number
Address____________________________ Fax Number_____________________
________________________________________Doctor's UPIN# (for medicare)________
Medicaid Provider #
Medicare Patient

"1 request that payment of authorized Medicare benefits be made on my behalf to Multi-Diagnostic Services. Inc. for any services furnished to me by Multi-Diagnostic Services, Inc. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Beneficiary Signature _____________________________  Date
MULTI-DIAGNOSTIC INSURANCE INFORMATION SHEET

JOB: ______________________

PLEASE PRINT CLEARLY.

PATIENT NAME (AS IT APPEARS ON YOUR INSURANCE CARD)

______________________________________________________________

NAME OF INSURANCE CARRIER -

POLICY NUMBER/ PLAN TYPE (HMO / PPO) ______________

HAVE YOU WAITED A YEAR SINCE YOUR LAST MAMMOGRAPHY? YES NO

ARE YOU THE PRIMARY POLICY HOLDER? YES NO

IF YOU CIRCLED NO ABOVE, PLEASE LIST PRIMARY POLICY HOLDER'S INFORMATION BELOW.

NAME _________________________________

ADDRESS ______________________________________________________

DATE OF BIRTH _______________ GENDER ______

DISCLAIMER

PLEASE MAKE SURE THIS IS YOUR CURRENT INSURANCE INFORMATION.
PLEASE REVIEW FOR ACCURACY. WE WILL USE THIS INFORMATION TO BILL YOUR MAMMOGRAM. IF OUR CLAIM IS DENIED BY YOUR INSURANCE COMPANY FOR INCORRECT INFORMATION, YOU WILL BE RESPONSIBLE FOR THE PAYMENT OF THE MAMMOGRAPHY FEE.

SIGNATURE ______________________ DATE ______________________________

MOBILE AND ON-SITE DIAGNOSTIC SERVICES
Patient Privacy Notice Acknowledgment
Form

The purpose of this form is to record acknowledgment of receipt of Privacy Notice, as required by the Health Information Portability and Accountability Act of 1996 (HIPAA). Should such acknowledgment be unobtainable, this form will document the company’s good faith attempt to acquire such acknowledgment.

Part A: I _______________________________ acknowledge receipt of the University Physicians {insert patient's name) Group Privacy Notice and Practices.
Signed:_________________________________                      Date: __________________

Part B:  MULTI-DI AGNOSTIC SERVICES, INCORPORATED, made a good faith attempt to obtain __________________________________________________________________________ (insert patient's name) acknowledgment of receipt of Privacy Notice, but was unable to do so for the following reason(s);

☐ Individual refused to sign
☐ An emergency situation prevented us from obtaining it
☐ Communications barriers prohibited obtaining it
☐ Other (please specify) ________________________

Signed:_________________________ Position: ______ ; _________ Date:____________
(Employee)

Part C: The first treatment encounter of the office with _______________________________ was by telephone on __________________, and a copy of the Notice of Privacy Practices of the office and a copy (insert date of phone call) of this Acknowledgement Form were mailed to the patient on such date, with a request to the patient to return to the office the completed Part A of this form.

Signed:_______ _______________________ Position: ___________________ Date:____________
(Employee)

The completed form is to be placed in the patient’s medical record.
MAMMOGRAPHIC EXAMINATION

CPT CODE                         FEE
77055 Unilateral Mammography
77056 Diagnostic Mammography
77057 Screening Mammography- Bilateral

77052 CAD- Computer Aided Detection

Co-Pay ________________________

DIAGNOSIS ICD.9.CM (CIRCLE)
611.72   Lump or mass in breast
611.9    Unspecified disorders of breast
V76.12   Breast screening, unspecified
V76.11   Screening mammogram for high-risk patient

________________________________________________________________________

Total Charge: ______________  Total Paid: __________  Balance Due: ______________