DR. ADAM G. CROUCH, INC., DBA
DIAGNOSTIC MEDICAL X-RAY AND IMAGING
MammoCoach
MAMMOGRAM HISTORY SHEET

NAME: ______________________________ DATE OF BIRTH: ___________ TODAY'S DATE: _________

PHYSICIAN: ____

ADDRESS , PHONE, FAX: ____

Do you feel a lump? ______________________________	Yes	No	Rt	Lt
Any localized pain, soreness, or discomfort? _________	Yes	No	Rt	Lt
Nipple discharge? _____________________________	Yes	No	Rt	Lt
Inverted nipple?_________________________________	Yes	No	Rt	Lt
Are any of the above a **NEW** finding? ______________	Yes	No		
History of previous breast cancer? _________________	Yes	No	Rt	Lt
Do you have breast implants? ______________________	Yes	No	Rt	Lt
What type? ____________________________________				
Fibrocystic breasts? ______________________________	Yes	No		
Have you had any injury to either breast? ___________	Yes	No	Rt	Lt
Any previous breast surgery? ______________________	Yes	No	Rt	Lt
When? _________ What type? ___________________				

Is there a family history of breast cancer? _____________ Yes No

Which relative? _____________ (Grandmother, mother, daughter, sister, aunt)

Please check one that applies Periods _____ Menopause ______ Hysterectomy ______

Age of first period _________ Age of menopause/hysterectomy ___________

Do you take hormones? ___________________________ Yes No

What type? Birth control ____ estrogen ______ thyroid ______ progesterone _______ other _______

Number of pregnancies _________

Did you breast feed? _____________________________ Yes No

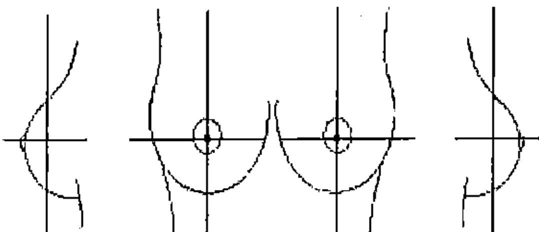
Do you practice breast self-examination? _____________ Yes No

Previous mammogram _____________________________ Yes No

When? ___________ Where? _______________________

____ OFFICE USE ONLY

RIGHT LEFT



Tolerated procedure: Well _________ moderately well ___________ poorly _____________

DMXI MammoCoach INSURANCE BILL

Date: ____________ M / F Age: _____ Date of Birth: ________________

Race: Asian / Native Hawaiian / Other Polynesian / African-American / Native American
White / More than One / Unknown

Ethnicity: Hispanic / Non-Hispanic Language of Preference: English / Other: ________________

Patient Name: ________________________________ SS# ___-__-____

Address: ____
(City) (State) (Zip code)

Home phone #: ___-___-____ Cell Phone# : ___-___-____

E mail address: ________________________ Pregnant: Yes / No

****

List of Medications:

___________________________________ ________________________________

___________________________________ ________________________________

___________________________________ ________________________________

___________________________________ ________________________________

Are you allergic to any medications? Yes / No

If so, which drugs: ____

____

Are you diabetic? Yes / No Recent bloodwork? Yes / No Date: _______________

Do you smoke? Yes / No
Circle one: Current- every day smoker / current- occasional smoker / former smoker / never smoked

INSURANCE BILL

This section must be completed in order to bill your insurance company:

Primary Insurance: ______________________ Employer: ____________________

Policyholder's name: ______________________ Date of birth: ________________

SS#: ___-__-____ Relationship: Self / Spouse / Child / Other

Secondary insurance: ____________________ Employer: ____________________

Policy holder's name: ______________________ Date of birth: ________________

SS#: ___-__-____ Relationship: Self / Spouse / Child / Other

****

HIPAA Privacy Notice

I acknowledge that I have received Dr. Adam G. Crouch Inc. dba DMXI's notice of privacy practices. I also give my permission to leave messages on my answering machine.

____ Date: ________________

Signature of patient or authorized representative

Printed Name: _________________________________

Dr. Adam G. Crouch, D.O., Inc. DBA
Diagnostic Medical X-ray and Imaging

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered and/or received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the practice as described in the notice.

Patient's Name: ____

Patient's Signature: ____

Date: ____

I allow the following people to have access to my health information:

______________________ Relationship: _______________ Phone: ____________

______________________ Relationship: _______________ Phone: ____________

______________________ Relationship: _______________ Phone: ____________

______________________ Relationship: _______________ Phone: ____________

YES or NO: I also give permission for the above named signatures to have access to my appointment and/or billing information.

DMXI
Mammo Coach Release Form
8390 TOD AVE, P.O. BOX 3257
BOARDMAN, OH 44512

DMXI will always compare this mammogram to your previous exams.
Please provide us with the facility where your last mammogram was done.

PHONE: 1-844-870-3694 FAX: 330-259-0413

I hereby authorize: Facility ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ________________ Fax: ________________

To release my mammograms and/or ________________ and reports taken on ________________ to DMXI Mammo Coach for the purpose of further review and/or comparison to additional studies.

I further authorize DMXI Mammo Coach to release my current films and/or reports to any physician or facility request, should follow-up treatment be necessary.

In the event that follow-up treatment is necessary, I request that the physician or facility providing that treatment release a record of the follow-up action taken along with any medical report(s) to DMXI MammoCoach to be included as part of my permanent file.

Name: ______________________________ Date of birth: ________________
(please print)

Signature: ______________________________ Date: ________________

Previous Name: ______________________________

Witness: ______________________________ Date: ________________

Submit films to: DMXI
MammoCoach
8390 Tod Ave, P.O. Box 3257
Boardman, OH 44512

Expiration date: ________________

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** __________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** __________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Screening Mammogram	May not be considered a covered service and/or medically necessary.	$245.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** __________ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** __________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** __________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** __________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Very important:

Please read, all paperwork must be complete prior to your appointment.

Below you will find a few tips you need to know prior to coming for your mammogram appointment.

- Be sure to complete all of the paperwork **before coming to your appointment.** This will allow all appointments to stay on time.

- **Please bring your insurance card and photo ID the day of the exam.**

- The top of the line of the release information sheet: Please list the facility where your last mammogram was performed.

- The privacy sheet: we need to know if anyone else can receive your results other than yourself and your Dr. (if not draw a line through it and sign)

- The history sheet: we need contact information for the physician you listed on your paperwork so the report can be sent to them. **This must be a current physician.**

- The insurance sheet- this is to verify your current coverage. All mammograms performed on the coach will be bill as preventative exams. You may check this with your insurance company if you would like.

- We do **screening mammograms only**; therefore **we cannot do the exam** if you are breast feeding or have breast fed within the last 6 months, have breast implants, lumps, pain, discharge, etc...

The company is Dr. Adam G Crouch Inc. - DMXI
PO Box 3257, 8390 Tod Avenue
Youngstown, OH 44513

The NPI number is 1699920744.
Tax ID number is 26-3533716.

Thank you.