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

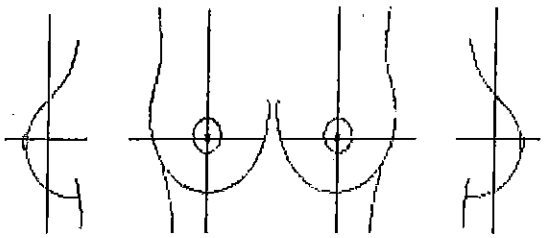
NAME: _____ DATE OF BIRTH: _____ TODAY'S DATE: _____

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

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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

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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: _____

DR. ADAM G. CROUCH, INC, DBA
DIAGNOSTIC MEDICAL X-RAY AND IMAGING

Patient's name: _____

ADVANCED BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

In the event that your insurance will not pay for the service(s) that are described below. Your insurance may not pay for all of your health care costs. Your insurance only pays for covered items and services when your insurance rules are met. The fact that your insurance may not pay for a particular service does not mean you should not receive it. There may be a good reason your doctor recommended it. Your insurance may not pay for

Screening Mammogram (77067)

because it may not be a covered service due to age, frequency, lapse of coverage, coverage not in effect at time of service, or considered unnecessary by the insurance company.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these services knowing that you might have to pay for them yourself. Before you make a decision about your options you should **read this entire notice carefully.**

Ask us to explain if you do not understand why your insurance may not pay.
Ask us how much these services will cost you. (Estimated cost $ 245.00), in case you have to pay for them yourself or through other insurance.

_____ **Option 1. YES. I want to receive these services.**
I understand that my insurance will not decide whether to pay unless I receive these services. Please submit my claim to my insurance. I understand that you may bill me for the services and that I may have to pay the bill while my insurance is making its decision. If my insurance does pay, DMXI will refund to me any payments I made to DMXI that are due to me. If my insurance denies payment, I agree to be personally and fully responsible for payment to DMXI. That is, I will pay personally either out of pocket or through any other insurance that I have. I understand I can appeal my insurance's decision.

_____ **Option 2. NO. I have decided not to receive these services.**
I will not receive these services. I understand that DMXI will not be able to submit a claim to my insurance and that I will not be able to appeal your opinion that my insurance will not pay.

_____ _____
Date Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collected about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance, your health information on this form may be shared with your insurance. They will keep your health information, which your insurance sees, confidential

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.