Bellingham Breast Center

Cary S. Kaufman M.D., F.A.C.S.
2075 Barkley Blvd. Suite 250
Bellingham, Washington 98226

1. NAME:_____DATE: _____

2. YOUR AGE:_____DATE OF BIRTH:_____

3. WHY ARE YOU HERE?_____
(PLEASE CIRCLE: routine exam, breast lump, breast pain, abnormal mammogram, second opinion?)

4. DO YOU PRACTICE SELF EXAM?_____ BRA CUP SIZE?_____

5. HAVE YOU EVER HAD BREAST LUMPS IN THE PAST? _____ BREAST BIOPSY? _____

6. HOW OLD WERE YOU WHEN YOU FIRST STARTED HAVING MENSTRUAL CYCLES?_____

7. HAVE YOU HAD CHILDREN?____NUMBER?____YOUR AGE AT FIRST LIVE BIRTH?_____

8. DID YOU BREAST FEED?_____HOW LONG?_____

9. HAVE YOU HAD ANY BREAST INFECTIONS, INJURY OR TRAUMA?_____

10. DO YOU HAVE ANY NIPPLE DISCHARGE? _____WHAT COLOR?_____

11. APPROXIMATE DATE OF LAST KNOWN MENSTRUAL PERIOD:_____

12. HAVE YOU EVER TAKEN BIRTH CONTROL PILLS? _____ WHEN & HOW LONG?_____

13. HAVE YOU TAKEN HORMONES?_____ WHICH ONES & HOW LONG?_____

14. DO YOU TAKE ANY OTHER MEDICATIONS?_____ PLEASE LIST WITH DOSES:_____
_____

15. IS THERE ANY FAMILY HISTORY OF BREAST CANCER? _____

WHICH RELATIVES AND AT WHAT AGE WERE THEY? _____

ANY OTHER CANCERS OR TUMORS? _____

16. HAVE YOU HAD ANY MAMMOGRAMS IN THE PAST? _____ APPROXIMATE DATES:_____

17. ON AN AVERAGE, WHAT IS YOUR DAILY INTAKE OF: COFFEE _____CHOCOLATE _____

TEA_____CAFFEINATED SODAS _____ ALCOHOL _____ SMOKING _____

18. LIST ALL PREVIOUS OPERATIONS YOU HAVE HAD:_____
_____

19. LIST ANY HOSPITALIZATIONS YOU HAVE HAD:_____
_____

20. DO YOU HAVE ANY ALLERGIES? _____ TO WHICH MEDICATIONS?_____

(CALCULATIONS:_____ _____)

Cary S. Kaufman M.D.

Practice limited to
Disorders of the Breast

American Board of Surgery
American College of Surgeons
Society of Surgical Oncology

Name and DOB:_____

REVIEW OF SYSTEMS

Do you now or have you had any **major** problems related to the following systems? Please circle Y (Yes) or N (No) and explain any YES answer in the space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other _____

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Eye Pain	Y	N

Other _____

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N

Other _____

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingle	Y	N

Other _____

Endocrine

Excessive Thirst	Y	N
Too Hot/Cold	Y	N
Tired/Sluggish	Y	N

Other _____

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N

Other _____

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/heartburn	Y	N

Other _____

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N

Other _____

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N

Other _____

Ear/Nose/Throat/Mouth

Ear Infections	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N

Other _____

Genitourinary

Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N

Other _____

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Short of Breath	Y	N

Other _____

Hematological/Lymphatic

Swollen Glands	Y	N
Blood Clotting	Y	N

Other _____

Psychological

Are you dissatisfied w/your life?	Y	N
Do you feel severely depressed?	Y	N
Do you use recreational drugs?	Y	N

Other _____

NAME _____
DATE _____

Bellingham Breast Center

Patient Satisfaction Survey – Follow-up Questionnaire

For each of the following statements,
enter a number from 1-5 which states how important the item is for you,
1 being LEAST important and 5 being MOST important.
Enter only one number for each line please.

A. Regarding my **office** interactions, grade us using a 1-5 scale: (1 LEAST to 5 MOST)

* The office staff greeted me in a friendly unrushed manner _____
* The office staff had my medical records ready for my appointment _____
* The office staff notified me of my scheduled appointment in this office _____
* The office staff arranged appointments that were suggested by the doctor _____
* The office staff wrote down all my appointments and gave them to me _____
* The office staff notified me if the doctor was running late _____
* The office staff kept my medical records confidential _____
* The office staff returned my phone calls _____
* The office billing staff was courteous when calling regarding my bill _____
* The office billing staff took care of billing my insurance company _____

B. Regarding **doctor** interactions, grade us using a 1-5 scale: (1 LEAST to 5 MOST)

* The doctor had my medical records necessary for my medical problem _____
* The doctor listened to my history regarding my medical problem _____
* The doctor listened to my concerns and questions about my medical problem _____
* The doctor examined me in a medically thorough manner _____
* The doctor saw me on time, close to my scheduled appointment time _____
* The doctor showed me where any medical abnormality was located on my body _____
* The doctor explains what my medical problem is in language I can understand _____
* The doctor made me comfortable when I asked questions _____
* The doctor explained what medical options existed for treatment of my problem _____
* The doctor told me what his first choice recommendation is for my treatment _____
* The doctor allowed me to make the final decision in choosing treatment for my problem _____
* The doctor accepted my choice of treatment even if it wasn't his first choice _____
* The doctor made me comfortable in making my choice of treatment _____
* The doctor explained the next steps prior to leaving my appointment _____

C. Measures of Distress: Using a scale from 1 (the least) to 10 (the most)
Often when an acute medical problem arises, multiple emotions are experienced and it is prudent to recognize these feelings. Distress can be the feelings of concern, worry, anxiety, fear, nervousness, unease, apprehension, or even panic. We'd like you to score your level of distress **AFTER YOUR 1st VISIT** on a scale from **1 (the least)** to **10 (the most)**. _____

When finished, please return to office staff. ***Thank you! Bellingham Breast Center***

Cary S. Kaufman MD, FACS M.D.

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PATIENT REGISTRATION

Patient Name: _____ **Sex:**_____
Last Name First Middle

Birth Date: _____-___-_____ **age**___ **Social Security#:** _____

Street Address: _____

City/State/Zip: _____

Mailing Address: _____

City/State/Zip: _____

H. Phone: _____ **Cell:** _____ **Marital Status:**_____

May we leave personal health care info, such as test results, on your voice mail? _____
Occupation: _____ **Work Phone:** _____

Please list an
Emergency contact: _____
Name Relationship Phone Number

Who Referred You to Us: _____

Who is your Primary Care Physician: _____ Phone: _____

What Pharmacy do you prefer: _____

TODAY'S DATE:_____ Person to share medical info with:_____

Ethnicity_____ Race_____ Email_____

What is your preferred language?_____

PRIMARY Co-Pay: _____

Insurance Company name: _____ ID# _____

Subscriber's Name: _____

Social Security #: _____ Group #: _____

Subscriber's Birth Date: _____

SECONDARY

Insurance Company name: _____ ID# _____

Subscriber's Name: _____

Social Security #: _____ Group #: _____

Subscriber's Birth Date: _____

Cary S. Kaufman MD, FACS – 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.

USES AND DISCLOSURE

Our practice collects personal health information on you that may be used for three primary purposes:

1. Treatment – For example, we will prepare a record of information each time we see you in or out of the office while you are under our care. This medical record is used to keep track of changes in your condition as well as remind us of your past care, treatment, allergies and other facts relevant to your overall health. This information may be passed on to other providers as part of a coordinated health care program for you.
2. Payment – We must report elements of your personal health information, such as specific treatments, visits, tests and surgeries along with related diagnoses to third party payers to properly determine benefits payable on your behalf for the services we render. We only report the minimum necessary information to process the claim.
3. Health Care Operations – In order to provide you with high-quality health care we often need to be able to use your personal health information for purposes such as pre-registering you at the hospital if you ever need admission, or providing our pharmacy with a prescription so that it is ready to pick up when you arrive. Again, we are committed to using the minimum necessary information to achieve these purposes.

   In addition, we will use or disclose your personal health information under the following circumstances:

   a. When we receive a valid authorization from you
   b. If you give us an oral authorization
   c. If we are required by law to disclose your personal health information to others such as public health agencies.

REQUIRED DISCLOSURES

We are required to disclose the information to you if you request it and we are required to disclose the information to the US DHHS for compliance determinations of this practice. We may disclose information about you without your authorization for the following reasons:

1. When required by law, for judicial proceedings or law enforcement
2. For uses and disclosures about descendants
3. Uses and disclosures for cadaver tissue donation
4. To avert a serious threat to public health or safety
5. Disclosures about abuse or neglect or domestic violence

Other uses and disclosures will be made only with your written authorization and you may revoke such authorization by writing to us at our practice address or delivering a written revocation to us in person. We may periodically call you to remind you of appointments and we may advise you of treatment alternatives and benefits that may be of interest to you based on your health condition or status.

YOUR RIGHTS

1. You have a right to request restrictions on the use and disclosure of your PHI (personal health information). Our practice is not obligated to accept your restrictions though. However, if we do accept the restriction it must be complied with fully on our part.
2. You have a right to inspect and have a copy of your PHI. If you would like a copy please request the information in writing or use a form available in our office for the request.
3. You have a right to request amendments to your PHI. We will not amend any information we did not create. We are not obligated to make an amendment to your PHI but we will include your request for the amendment as part of your PHI.
4. You have a right to an accounting for the prior six years (but no earlier than the effective date of this notification) for uses and disclosure for purposes other than treatment, payment and health care operations of our practice.
5. You have a right to a paper copy of this notification. The current version will be provided to you at your request.

OUR DUTIES

1. We are obligated by law to protect your privacy and we will do our utmost to fulfil that duty to you. We will abide by all the terms in this notification but we reserve the right to change the terms of this notice and the personal health information it protects. You are entitled to a copy of these changes. We will include updated copies with statements mailed to patients, and we will have a current copy in our office at all times.
2. We will do our very best to make certain your rights are protected and we carry out our responsibilities to you. If you have any complaint we encourage you to contact us. It is our sincere desire to preserve your privacy and fulfill our duties. We will take no retaliatory action against any person for exercising their right to the resolution of a grievance. To the contrary we encourage your comments and criticisms. If we cannot resolve the issue for you, you have the right to file a grievance and make a complaint to the US Department of Health and Human Services.

To make a complaint or ask any questions concerning this policy, please contact the office manager directly at (360)-671-9877.

Effective Date: April 15, 2013

Cary S. Kaufman M.D., F.A.C.S.
2075 Barkley Blvd. Suite 250
Bellingham, Washington 98226

Patient Consent for Use and Disclosure of Protected Health Information

In signing this form, you consent to the use and disclosure of your protected health information by [practice], our staff, and our business associates strictly for the purpose of treatment, payment and health care operations.

You acknowledge you have had an opportunity to review our ***Notice of Privacy Practices*** prior to signing this consent. We encourage you to review our ***Notice of Privacy Practice***s carefully. It provides more detail on how we may use and disclose your information. The ***Notice of Privacy Practices*** may change. A current copy may be requested when you are being seen as a patient, or by contacting our manager at 360-671-9877.

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing. However, we reserve the right to deny your request. If we grant your request, we are bound by the terms of the agreement.

You may also revoke this consent in writing; however, information on any treatment/service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment, or health care operations. Refer to the ***Notice of Privacy Practices*** for further information.

By signing this form, I grant my consent for the practice to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

Signature of Patient or Surrogate Decision Maker: _____ **Date:** _____

Relationship to Patient/ Legal Authority *(if applicable)*: _____

For Practice use only

Failure to obtain consent Check the appropriate reason:

☐ **Indirect Treatment Relationship** ☐ **Emergency treatment**
☐ **Substantial Communication Barrier** ☐ **Refusal to Sign** ☐ **Other**

Description:

_____ _____
Practice Signature **Date**

_____ _____
Witness **Date**

Financial Policy
Cary S. Kaufman, M.D., F.A.C.S.

This is an agreement between Dr. Cary S. Kaufman and the Patient named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Dr. Cary S. Kaufman.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payment options if you have insurance:
1. You provide all necessary and valid insurance information, we will bill your insurance for you and bill you for any remaining balances. You will pay all remaining balances you are billed for within 30 days of the first statement date.
2. You choose to pay your copay/deductible of $_____and any out-of-pocket portions at the time services are rendered by __cash, __check, or __credit card.
3. You choose to pay all of your treatment by ___cash, __check, or __credit card. We will request your insurance carrier send their payment directly to you.

Payment options if you have no insurance:
1. You choose to pay in full by __cash, __check, or __credit card on the day that treatment is rendered.
2. On treatment involving surgery fees you may choose to pay 50% on the preparation date and the balance in three weeks.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment or nonpayment from the insurance company. In the case of reduced payment or nonpayment due to lack of referral you agree to pay all charges in full.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one (1%) percent per month or an **ANNUAL PERCENTAGE RATE** of twelve (12%) percent. The finance charge on your account is computed by applying the periodic rate (1%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Returned checks: There is a fee (currently $25) for any checks returned by the bank.

Missed appointment fee: The second time a patients does not show up on time for an appointment, or cancels with less than 24 hours notice, a $20 fee will be charged. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

<The Financial Policy continues on page 2.>

Financial Policy Page 2

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Whatcom County, Washington.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee (currently $25) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Assignment of Benefits: I authorize my insurance benefits be paid to Cary S. Kaufman, M.D. (Bellingham Breast Center). I authorize the doctor and/or insurance company to release any information required for the processing and/or payment of my claims.

Patient's name:_____

Guarantor (if not the patient):_____

Signature:_____ Date:_____

Co-Signature:_____ Date:_____

CURRENT MEDICATIONS			ALLERGIES TO MEDICINES	
NAME OF MEDICINE	DOSE IN MG.	# TIMES PER DAY	NAME OF ALLERGIC MEDICINE	TYPE OF ALLERGIC REACTION
			OTHER ALLERGIES?	
			LATEX? IODINE? TAPE?	
NON-PRESCRIPTION MEDICINES				
			CURRENT SMOKER or tobacco user?	
			FORMER SMOKER?	
			NEVER SMOKED?	
			HANDOUT GIVEN **(office use only)**	
PRINT NAME				
SIGNATURE				
HEIGHT				
WEIGHT				
BP				
PULSE				
O2 SAT				

As a patient at our office, we would like to inform you that your total health is important to us.

Notice to all our new and existing patients:

If you are a current tobacco user, we are obligated to inform you that smoking is harmful to your health and inhibits wound healing.

For best results after surgery, it is recommended that you seek help with smoking cessation prior to any surgery.

Please consult with your primary care doctor for assistance and resources with smoking cessation.

Initial and date:

_____