



Thank you for participating in our No–Cost Breast Cancer Screening Program. This document will explain how to prepare for your visit to our Mobile *Care Clinic*.

**Please Note: We will not perform a mammogram if you are pregnant or think that you may be pregnant, nursing or have stopped nursing for less than 6 months.**

#### **On the day of your mammography:**

- Plan to wear a 2-piece outfit. That way you will only have to remove your top during the mammogram and Clinical Breast Exam (CBE).
- Do not use deodorant, lotion, perfume or powder under your arms or on your chest. Certain metallics in these products can appear on the screening as spots.
- Take your medicines and eat as usual.

#### **Things to know:**

- If you schedule your mammogram appointment a week before or during your period it is likely you will experience inflammation and breast tenderness.
- You should bring any previous mammogram films to your appointment, especially if they were performed at a different facility and if your previous mammogram results have been irregular.
- When you arrive at our mobile *Care Clinic* please check-in with our personal and inform them of your appointment time.

#### **What to Expect:**

You will need to complete paper work similar to what you complete at your doctor's office. After your paperwork has been reviewed you will be directed to the mammography room for your mammogram. It takes approximately 10 minutes to perform a mammography. After the mammography is completed you will be introduced to our nurse who will perform your CBE. A CBE is a physical examination of the breast. After the examination is completed, the nurse will teach you how to do your own self breast exam and what to look out for so you can monitor you breasts on a monthly basis.

Your results will be mailed in approximately 2 weeks in the envelope you address earlier. If you have questions regarding your results you may call our medical provider Multi-Diagnostics Services at 718-454-8556.

*Thank you!*

# Multi-Diagnostic Services Inc.

139-16 91<sup>st</sup> Avenue ~ Jamaica, NY 11435 ~ 718.454.8556 ~ Fax 718.454.7950

Please Print. Form must be filled out completely

## Location of Screening

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone# (\_\_\_\_) \_\_\_\_\_ Work Phone# (\_\_\_\_) \_\_\_\_\_ Social Sec# \_\_\_\_\_

**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 \_\_\_\_\_  
 Hormones NO YES \_\_\_\_\_  
 Thyroid NO YES \_\_\_\_\_

Age you began menstruating? \_\_\_\_\_  
 Number of pregnancies? \_\_\_\_\_  
 Your age at first pregnancy? \_\_\_\_\_  
 Date of last period? \_\_\_\_\_

**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?**

Mastectomy	NO	YES	_____	R L Both	NO	YES
Lumpectomy	NO	YES	_____	R L Both	NO	YES
Breast Biopsy	NO	YES	_____	R L Both	NO	YES
Drainage of Cyst	NO	YES	_____	R L Both	NO	YES
Breast Implants	NO	YES	_____	R L Both	NO	YES
Other	_____					

**Do you have any of the following NOW?**

Fibrocystic Disease NO YES  
 Breast Lumps NO YES R L Both  
 Tenderness NO YES R L Both  
 Breast Pain NO YES R L Both  
 Skin Retraction NO YES R L Both  
 Nipple Discharge NO YES R L Both  
 If yes, what color? \_\_\_\_\_

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

**Family History of Breast Cancer? (Please Circle)**

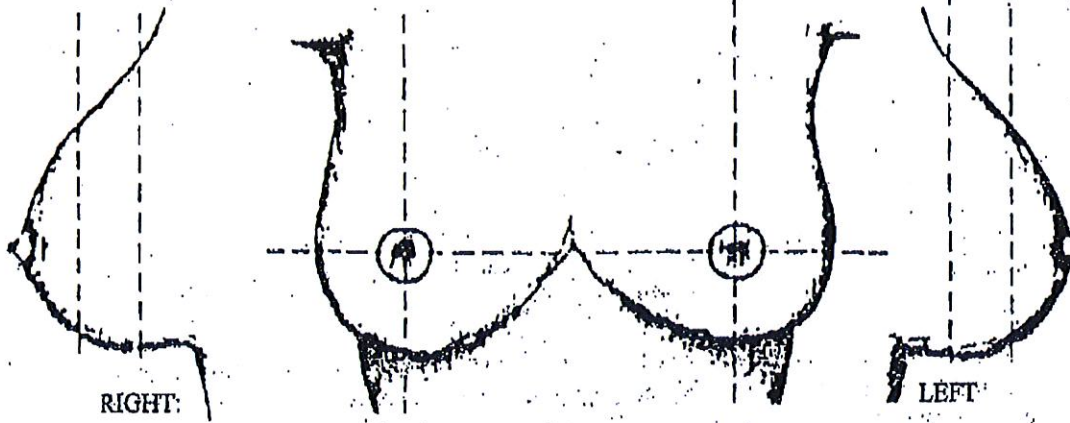
Mother NO YES  
 Aunts NO YES Mother's or Father's side?  
 Sisters NO YES  
 Grandmothers NO YES Mother's or Father's side?  
 Daughters NO YES

**Previous Mammogram?**

When? \_\_\_\_\_

Where? \_\_\_\_\_

If Yes, at what age (approximately) was the person first diagnosed? \_\_\_\_\_ Date of last Clinical Breast Exam? \_\_\_\_\_



(COVER) Technicians Signature \_\_\_\_\_

**PLEASE READ AND SIGN ACKNOWLEDGING ITEMS 1-4**

1. I \_\_\_\_\_ 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. I 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. I 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. I 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**

"I 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 \_\_\_\_\_

# CANCER SERVICES PROGRAM CLINICAL BREAST EXAM FORM

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI MM/DD/YR MM/DD/YR

**Review of Patient History**

Patient noticed changes in breasts since last visit? Site code   
 No \_\_\_ Yes \_\_\_ Describe \_\_\_\_\_  
 Patient has a personal or family history of breast cancer?  
 No \_\_\_ Yes \_\_\_ Who? \_\_\_\_\_ What age? \_\_\_\_\_  
 Patient noted spontaneous nipple discharge?  
 No \_\_\_ Yes \_\_\_ Describe \_\_\_\_\_

**Visual Exam:**

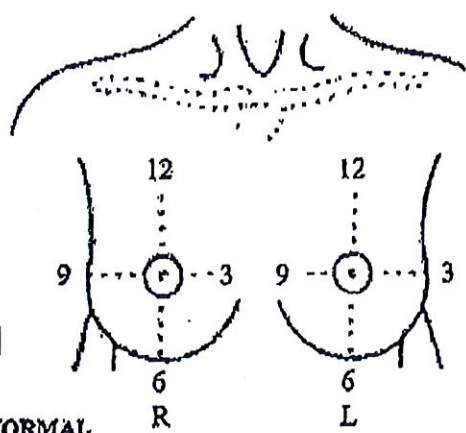
Skin:  Normal/Benign  Scar(s)  Dimpling  Other: \_\_\_\_\_  
 Nipples:  Everted  Inverted  Retraction

**Physical Exam:**

Lymph Nodes  +  - **Right**  +  - **Left**  
 (Axillary/Clavicular)

**Diagram Documentation Codes**

Scar +++      Nodularity ≡      Mole \*  
 Fibrocystic Area      Node ○      Dimpling △  
 Mass ●



Describe all clinical exam findings, including NORMAL and ABNORMAL (indicate size, shape, mobility, location of palpable findings).

Findings: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Plan: \_\_\_\_\_

Referral: No \_\_\_ Yes \_\_\_ (explain) \_\_\_\_\_

**Breast Findings: Check one box only**

- 1. Normal, Benign, Fibrocystic – Rescreen in 1-2 Years
- 2. Probably Benign – Repeat Exam in 3-6 months
- 3. Mass or Other Findings – Immediate Testing

Name of Examiner (please print) \_\_\_\_\_

Signature of Examiner \_\_\_\_\_ Date \_\_\_\_\_

*This report should be maintained as part of the patient medical record.*

05/22/09



Client ID Number: \_\_\_\_\_

Partnership Name: \_\_\_\_\_

Fax Number: \_\_\_\_\_

## CONSENT FOR CANCER SERVICES PROGRAM PARTICIPATION

### About the Cancer Services Program (CSP) Partnership

The CSP Partnership is a New York State Department of Health (NYSDOH) program that works with contract administrators, and with doctors, nurses and other health care providers to offer free, age-appropriate, risk-based screening for breast cancer, cervical (opening of the womb) cancer, and colorectal (the colon and rectum) cancer. Screening tests can help find these cancers in early stages when they may be easier to treat. Sometimes, when these cancers are found and treated early, they can be cured. Contract administrators work with you, health care providers and the NYSDOH to provide the services described in this consent.

### The Age-Appropriate, Risk-Based Screenings Offered by the CSP are:

- Mammograms and clinical breast exams for breast cancer
- Pap tests and pelvic exams for cervical cancer
- Take home fecal tests (FIT or FOBT) for colorectal cancer
- Screening colonoscopy for men and women at increased risk for colorectal cancer (this means they have a greater chance of getting colorectal cancer)

### People Who Have Abnormal Screening Tests (the screening tests show they may have one of these cancers) May Also Have the Following Services from the CSP Partnership:

- Diagnostic tests: These are tests and exams that check to see if cancer is there.
- Case management: People help you get to the diagnostic tests by helping make appointments, finding a way to appointments, finding child care, and many other ways to make it easier to get to the important diagnostic test appointments.
- Help finding treatment if cancer is found.
- Help getting in the Medicaid Cancer Treatment Program if you meet the program eligibility (rules). The Medicaid Cancer Treatment Program offers full Medicaid insurance for people with breast, cervical, colorectal or prostate cancer who meet the program eligibility (rules).

### Income and Insurance Eligibility

Free cancer screening by the CSP is only offered to women and men who meet income and health insurance eligibility (rules). Income eligibility means that the total amount of money earned by people living in your house must be below a certain amount for you to get free CSP services. CSP services are also offered to women and men who do not have health insurance (including Medicaid or other public insurance) or whose health insurance does not pay for cancer screenings. CSP services may also be offered to women and men who have health insurance, but cannot afford to pay the insurance co-pay, deductible, or spend down. The CSP partnership staff or health care provider will give you information about income and health insurance and talk to you about whether or not you meet these program rules.



Client ID Number:	_____
Partnership Name:	_____
Fax Number:	_____

**Signing this consent means that:**

- I have read the program information on page 1 and have talked to a CSP Partnership staff or provider and understand the services being offered to me by the CSP.
- I agree to be in this program and understand that by agreeing to be in this program, I give permission to the New York State Department of Health, contract administrators and health care providers, including doctors, clinics and/or hospitals to release (share) information about me. I understand this information includes financial and insurance information and medical information about me and related to my breast, cervical and/or colorectal cancer screening and any related diagnostic and treatment care I receive. I understand this information will be released (shared) to other health care providers, contract administrators, other staff, health care providers or agencies participating in the CSP Partnership and the New York State Department of Health for my health care, treatment and follow-up, and for case management, tracking and payment purposes.
- I understand that information about me and my medical information will be released only as allowed by this consent or as allowed or required by law.
- I understand that this consent is for CSP cancer screening and related diagnostic and treatment services and case management, as needed and as provided under the CSP Partnership.
- I understand that I may choose not to have the services that are offered to me at any time.
- I understand that someone will contact me if I am found to have an abnormal screening test (my screening test shows that I may have cancer). Case management services are provided to help me to get the recommended diagnostic follow-up testing and treatment, if needed. I understand that case management services are provided at no cost to me and that I can choose not to have the service at any time.
- I understand that my healthcare provider may recommend tests or procedures that may not be paid for under this program.

**Attestation of Eligibility**

A CSP Partnership staff or provider told me about the program services and eligibility requirements and answered any questions I had. By signing this consent, I attest that to the best of my knowledge, I understand this information and by checking the boxes below, the following is true. I understand that the CSP Partnership and the New York State Department of Health may verify (check) the information I have provided herein.

*I meet the following income eligibility requirements (choose one):*

- My household income is at or below 250% of the Federal Poverty Guideline (FPG).
- My household income is above 250% of the FPG, but I cannot afford cancer screening/s.

*I meet the following insurance eligibility requirements (choose one):*

- I do not have health insurance of any type (this includes Medicare, Medicaid, Family Health Plus, or other public or private insurance).
- My health insurance deductible, monthly spend down, or co-payment is too high and prevents me from getting cancer screening services or my health insurance does not provide coverage for cancer screening and/or diagnostics.

I authorize information about my services to be left on my answering machine.

**Client Information and Signature**

Client Name (Print) \_\_\_\_\_ DOB \_\_\_\_\_

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Partnership Witness (Signature) \_\_\_\_\_ Date \_\_\_\_\_

## 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 \_\_\_\_\_  
(insert patient's name)  
acknowledge receipt of the University Physicians  
Group Privacy Notice and Practices.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

**Part B:** MULTI-DIAGNOSTIC 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 \_\_\_\_\_  
(insert patient's name)  
was by telephone on \_\_\_\_\_  
(insert date of phone call)  
and a copy of the Notice of Privacy Practices of the office and a copy of this Acknowledgment 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

## American-Italian Cancer Foundation (AICF) HIPAA Authorization to Disclose Health Information

**ALL FIELDS MUST BE COMPLETED**

**THIS FORM MAY NOT BE USED FOR RESEARCH OR MARKETING, FUNDRAISING OR PUBLIC RELATIONS AUTHORIZATIONS**

<b>PATIENT NAME/ADDRESS</b>	<b>DATE OF BIRTH</b>	<b>PATIENT SSN</b>				
	<b>MEDICAL RECORD NUMBER</b>	<b>TELEPHONE NUMBER</b>				
<b>NAME OF HEALTH PROVIDER TO RELEASE INFORMATION</b>	<b>SPECIFIC INFORMATION TO BE RELEASED:</b> Information Requested: _____ Treatment Dates from _____ to _____					
<b>NAME &amp; ADDRESS OF PERSON OR ENTITY TO WHOM INFO. WILL BE SENT</b>	<b>INFORMATION TO BE RELEASED</b> (If this box is checked, you are authorizing the release of this type of information). Please note: unless all of the boxes are checked, we may be unable to process your request. <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Alcohol and/or Substance Abuse Program Information</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Mental Health Information</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Genetic Testing Information</td> <td style="border: none;"><input type="checkbox"/> HIV/AIDS-related Information</td> </tr> </table>		<input type="checkbox"/> Alcohol and/or Substance Abuse Program Information	<input type="checkbox"/> Mental Health Information	<input type="checkbox"/> Genetic Testing Information	<input type="checkbox"/> HIV/AIDS-related Information
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<input type="checkbox"/> Genetic Testing Information	<input type="checkbox"/> HIV/AIDS-related Information					
<b>REASON FOR RELEASE OF INFORMATION</b> <input type="checkbox"/> Legal Matter <input type="checkbox"/> Individual's Request <input type="checkbox"/> Other (please specify): _____	<b>WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one)</b> <input type="checkbox"/> Event: _____ <input type="checkbox"/> On this date: _____					

I, or my authorized representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.

I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.

I understand that if my medical and/or billing records contain information relating to **ALCOHOL or SUBSTANCE ABUSE, GENETIC TESTING, MENTAL HEALTH, and/or CONFIDENTIAL HIV/AIDS RELATED INFORMATION**, this information will not be released to the person(s) I have indicated unless I check the box(es) for this information on this form.

I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 212.480.2493 or the New York City Commission of Human Rights at 212.308.7450. These agencies are responsible for protecting my rights.

I understand that I have a right to refuse to sign this authorization and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this authorization, AICF cannot honor my request to disclose my medical and/or billing information.

I understand that I have a right to request to inspect and/or receive a copy of the information described on this authorization form by completing a Request for Access Form. I also understand that I have a right to receive a copy of this form after I have signed it.

I understand that if I have signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that AICF has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage.

To revoke this authorization, please contact the facility Health Information Management department processing this request.

**I have read this form and all of my questions have been answered. By signing below, I acknowledge that I have read and accept all of the above.**

<b>SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE</b>	<b>IF NOT PATIENT, PRINT NAME &amp; CONTACT INFORMATION OF PERSONAL REPRESENTATIVE SIGNING FORM</b>
<b>DATE</b>	<b>DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF PATIENT</b>

If AICF has requested this authorization, the patient or his/her Personal Representative must be provided a copy of this form after it has been signed.

AICF USE ONLY	
Date Received:	Initials of HIM employee processing request
Date Completed:	Comments:





Date: \_\_/\_\_/\_\_

Location:

American – Italian Cancer Foundation  
Mobile, No-Cost Breast Cancer Screening Program

Your Age: \_\_\_\_\_ Zip code: \_\_\_\_\_

**Gender**

- Female       Male       Other: \_\_\_\_\_

**What is your Primary Language?**

- English       Spanish       Korean       Chinese  
 Other: \_\_\_\_\_

**What is your Ethnicity?**

- Hispanic or Latino(a)       Not Hispanic or Latino(a)

**What is your Race? (check all that apply)**

- American Indian or Alaska Native  
 Asian  
 Black or African American  
 Native Hawaiian or other Pacific Islander  
 White  
 Other: \_\_\_\_\_

**What is your annual household income?**

- \$5,000 or less  
 \$5,001 - \$10,000  
 \$10,001 - \$15,000  
 \$15,001 - \$25,000  
 \$25,001 - \$50,000  
 More than \$50,000