American Italian Cancer
FOUNDATION
No-Cost Breast Cancer Screening

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 91st 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	

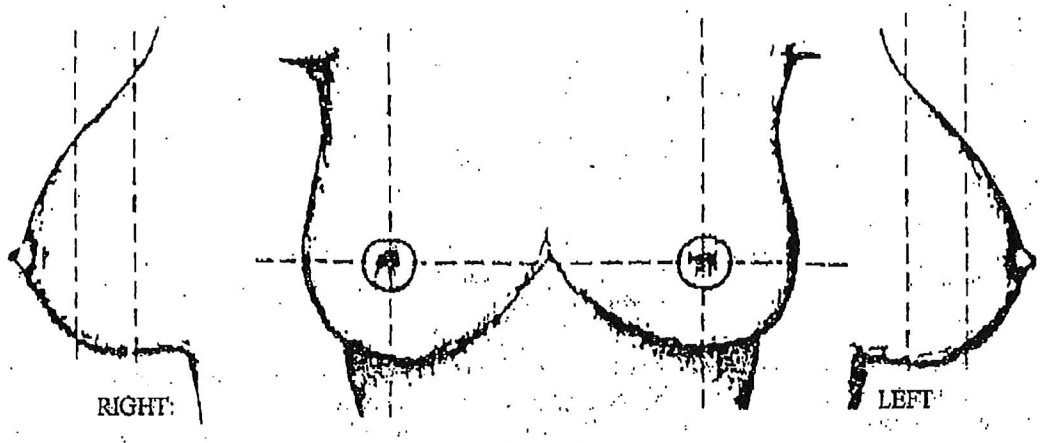
If Yes, at what age (approximately) was the person first diagnosed?_____.

Previous Mammogram?

When?_____

Where?_____

Date of last Clinical Breast Exam? _____



⇓OVER⇓ 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.

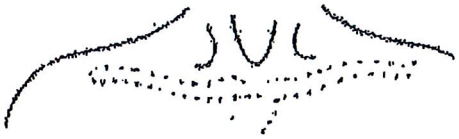
Beneficiary Signature _____ Date _____

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

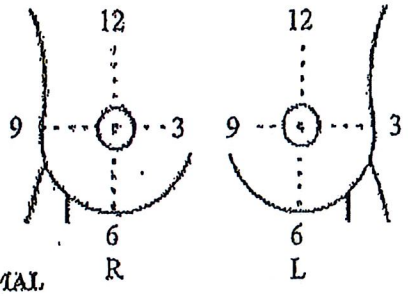


Physical Exam:

	Right		Left	
Lymph Nodes (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

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

PATIENT NAME/ADDRESS	DATE OF BIRTH	PATIENT SSN
	MEDICAL RECORD NUMBER	TELEPHONE NUMBER

NAME OF HEALTH PROVIDER TO RELEASE INFORMATION	SPECIFIC INFORMATION TO BE RELEASED: Information Requested_____ Treatment Dates from_____ to_____
NAME & ADDRESS OF PERSON OR ENTITY TO WHOM INFO. WILL BE SENT	INFORMATION TO BE RELEASED (if the box is checked, you are authorizing the release of that type of information). Please note: unless all of the boxes are checked, we may be unable to process your request. ☐ Alcohol and/or Substance Abuse Program Information ☐ Mental Health Information ☐ Genetic Testing Information ☐ HIV/AIDS-related Information
REASON FOR RELEASE OF INFORMATION ☐ Legal Matter ☐ Individuals Request ☐ Other (please specify):_____	WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one) ☐ Event:_____ ☐ 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 212.306.7450. 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.

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

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:

American Italian Cancer FOUNDATION
Research for Life

Multi-Diagnostic Services, Inc.

139-16 91st Avenue
Jamaica, New York 11435
718 454-8556
Fax: 718 454-7950

MULTI-DIAGNOSTIC INSURANCE INFORMATION SHEET
PLEASE PRINT CLEARLY.- AICF JOBS

PATIENT NAME (AS IT APPEARS ON YOUR INSURANCE CARD)

_____

NAME OF INSURANCE PLAN:_____

POLICY NUMBER/MEMBER NUMBER & GROUP NUMBER:_____

POLICY TYPE (HMO/PPO):_____

DOB: _____ GENDER: M F

HAVE YOU WAITED A YEAR (12 FULL MONTHS) 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 _____
RELATIONSHIP TO PATIENT _____

DISCLAIMER

PLEASE MAKE SURE THIS IS YOUR CURRENT INSURANCE INFORMATION. PLEASE REVIEW FOR ACCURACY. WE WILL USE THIS INFORMATION TO BILL YOUR MAMMOGRAM.

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 _____ acknowledge receipt of the University Physicians
(insert patient's name)
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 _____ was by
(insert patient's name)
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

Research for Life®
American Italian Cancer Foundation

Office Use Only
Date: ___/___/_____
Location:

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

Your Age: _____ **Zip code:**_____

Gender

O Female O Male O Other:_____

What is your Primary Language?

O English O Spanish O Korean O Chinese
O Other:_____

What is your Ethnicity?

O Hispanic or Latino(a) O Not Hispanic or Latino(a)

What is your Race? (check all that apply)

O American Indian or Alaska Native
O Asian
O Black or African American
O Native Hawaiian or other Pacific Islander
O White
O Other:_____

What is your annual household income?

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