

Dr. Marilyn B. Sandford
Alaska Breast Care and Surgery, LLC
3851 Piper Street U 462
Anchorage, AK 99508
Phone: 562-6262; Fax: 562-6267

Patient Information

Patient Last Name:		First Name:		M.I.
DOB:	SSN:		Home Phone:	
Mailing Address:			Cell Phone:	
City:	State:	Zip Code:	Work Phone:	
Local Contact # (if from out of town):		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated		
Patient Employer:		Patient Occupation:		
Spouse/Partner or Parent Name:		Contact Number:		
Spouse/Partner/Parent Employer:		Work Number:		
Referring Physician:		Primary Care Physician:		

Billing Information

Primary Insurance Company:	Name of Subscriber:
Policy #:	Group #:
Secondary Insurance Company:	Name of Subscriber:
Policy #:	Group #:

Ethnicity - Race – Language

<p><i>Do you consider yourself Hispanic or Latino?</i></p> <p><input type="checkbox"/> I am Hispanic or Latino. <input type="checkbox"/> I am not Hispanic or Latino. <input type="checkbox"/> I don't know. <input type="checkbox"/> I decline to answer.</p>	<p><i>What category best describes your race? (You may choose more than one.)</i></p> <p><input type="checkbox"/> White or Caucasian <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native American or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown <input type="checkbox"/> I decline to answer.</p>	<p><i>What language do you prefer speaking with your health care provider?</i></p> <p><input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Other _____</p>
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Financial Agreement and Authorization for Treatment

My signature authorizes treatment and I agree to pay all fees and co-payments for services not covered by my health care plan. I understand that all charges are my responsibility regardless of insurance coverage and that co-pays are due at the time of service. Fees are due and payable in full within thirty (30) days following the statement closing date.

I hereby authorize the release of any information required to process my insurance claim(s). I hereby authorize my insurance benefits to be paid directly to Alaska Breast Care and Surgery, LLC.

Signature:	Date:
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Dr. Marilyn B. Sandford
Alaska Breast Care and Surgery, LLC
3851 Piper Street, Suite U-462
Anchorage, AK 99508

Patient Name:	Patient Date of Birth:
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Release of Personal Health Information
Family and Friends

*Please list below, any **family or friends** to whom we may release information should they contact our office regarding your medical condition.*

I authorize Alaska Breast Care and Surgery, LLC to release my personal health information (PHI) to the following- Please list phone numbers in the event that we need to contact these people.

1. _____ Relationship: _____ Phone Number: _____
2. _____ Relationship: _____ Phone Number: _____
3. _____ Relationship: _____ Phone Number: _____
4. _____ Relationship: _____ Phone Number: _____

By signing below, I agree that Alaska Breast Care and Surgery, LLC may release my PHI to the abovementioned individual(s). I understand that I may revoke this authorization at any time by providing a written notice of revocation to the Privacy Officer at the address indicated below. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on ____/____/____ or six (6) months after being signed.

Privacy Officer
 Alaska Breast Care and Surgery, LLC
 3851 Piper Street, Suite U-462
 Anchorage, AK 99508

Your request will be processed within 48 hours unless otherwise specified. Please call (907) 562-6262 if you have additional questions.

Signature:	Date:
Printed Name:	

Privacy Policy

I acknowledge receipt of Alaska Breast Care and Surgery, LLC's Privacy Practice Policies related to HIPAA.

Signature:	Date:
Printed Name:	

Dr. Marilyn B. Sandford
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Patient Notice of Billing Practices

Medical Services provided by Alaska Breast Care and Surgery, LLC are payable at the time of service. We accept the following:

- Cash, Personal Checks, Money Orders, Debit Cards, MC, and Visa
- Insurance is billed as a *courtesy* for our patients. We do collect office visit payments at the time of the visit. **For all procedures done in the office, your co-pay is payable at the time of service; for all surgeries, 20% of the estimated fee is payable at the time the procedure is scheduled.**
- Payment plan options are offered for certain circumstances. If you are in need of a payment plan option, please ask to speak to the Practice Manager or Billing Department Supervisor. All patient payments under \$500 are to be paid in full within *three* months. Payment plans over \$1000 are to be paid in full within *six* months.

Our preference is to work with our patients as much as possible; however, any delinquent account balances will be forwarded to Cornerstone Credit Services. Accounts referred to a collection agency may be assessed additional fees. These fees are assessed by the collection agency and are in addition to the clinic fees due Alaska Breast Care and Surgery, LLC. All NSF checks will be assessed a \$25.00 NSF fee.

Private Insurance

We bill most private policies as a courtesy to our patients. We allow a 30-day grace period for insurance companies to respond to submitted claims. If an insurance company does not respond to a submitted claim within 30 days, the amount of that claim becomes due in full by the patient. The patient is also responsible for all balances not paid by the insurance companies.

****No Show/Cancellation Policy****

We strive to see patients in our office as soon as possible. So that everyone can be seen in a timely fashion, we ask that you contact our office at least 2 business days before your appointment if you need to cancel and reschedule. If you fail to contact our office 24-hours in advance or if you do not show for your appointment, you will be assessed a \$25.00 fee.

Medicare/Medicaid

We accept Medicare and Medicaid. As a provider participating in the Medicare and Medicaid programs, we are required to collect applicable co-payments *at the time of service*. If we believe a procedure may not be a covered service under either of these programs, we will provide you with this information and the estimated fees prior to the procedure. In such cases, you will be asked to sign a waiver indicating you understand that the procedure may not be covered and that you will be responsible for the fees associated with the procedure should your health care benefits not cover the fees.

Out of State Patients

Patients who are visiting Alaska or are foreign exchange students and require our services will be required to make full payment at the time services are rendered. We will provide you with a receipt that you may submit to your insurance for reimbursement.

Municipality of Anchorage Ordinance 2017-26

As directed by Municipality of Anchorage Ordinance 2017-26, we are more than happy to provide you with an estimate of your services should you request it. In addition to charges incurred at our office, there may be additional charges from other facilities, such as pathology, hospital facility fees, radiology fees, etc. These fees will only be assessed as appropriate to your visit. In the case of those with out of network insurance carriers, you may incur out of network charges. Please feel free to ask for our office manager if you have any questions concerning MoAO2017-26.

I have read the above payment options and understand my financial responsibility to Alaska Breast Care and Surgery, LLC. (If you have additional questions, please ask to speak to the Practice Manager prior to your appointment.) Thank you for allowing us to be part of your health care!

Patient or Guardian Signature

Date Signed

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Consent for Photographing for Security and/or Health Care Operations

____ (Patient/Representative initials) **I consent** to photographs and images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g. tracking of cosmetic outcomes in surgical patients). Surgical photos will be limited to the torso. I understand that the facility retains the ownership rights to the images. I will be allowed to request access to or copies of the images when technologically feasible unless otherwise prohibited by law. I understand that these images will be securely stored and protected. Images in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment, or health care operations purposes or otherwise permitted or required by law.

____ (Patient/Representative initials) **I do not consent** to photographs and images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g. tracking of cosmetic outcomes in surgical patients).

Consent to Text Usage for Health Care Communications

Patients in our clinic may be contacted via text message by their provider to provide general health reminders/information. I understand that once I have consented to receive communication via text, I still have the right to revoke that consent at any time.

Dr. Sandford may also send and receive text messages, phone calls, faxes, and/or emails that have my name and phone number included in it. I am aware that no form of communication is technically "secure."

The practice does not charge for this service, but standard messaging rates may apply as provided in your wireless plan (contact your carrier for pricing and plans).

____ (Patient/Representative initials) **I consent to receive text messages** from the practice at my cell phone. I understand that this request to receive text messages will apply unless I request a change in writing (please see revocation section below).

The cell phone number I authorize to receive text messages is _____

OR

____ (Patient/Representative initials) I decline to receive text messages for health care information from my provider.

If you have previously consented to receive communication via text message and wish to remove the consent, please contact our office and we will update your account preferences to reflect this change.

Signature:	Date:
Printed Name:	

Alaska Breast Care & Surgery, LLC

Past Medical History

Name: _____ DOB: _____

Medicines Prescribed by your Physician

Please list all the medications you are currently taking.

Name of Medication	Dose	How often you take it

Over-the-counter Medications/Supplements

Name of Medication	Dose	How often you take it

Allergies to Medications: What medications are you allergic to and what happens if you take them?

Medication	Reaction

Latex Allergy? **Y N**

Other Contact Dermatitis? _____

Please place an **X** in the box in front of all the conditions with which you have been diagnosed:

Cancer

<input type="checkbox"/>	Brain		<input type="checkbox"/>	Lung		<input type="checkbox"/>	Thyroid
<input type="checkbox"/>	Breast		<input type="checkbox"/>	Lymphoma		<input type="checkbox"/>	Other
<input type="checkbox"/>	Cervical		<input type="checkbox"/>	Ovarian			
<input type="checkbox"/>	Colon		<input type="checkbox"/>	Prostate			
<input type="checkbox"/>	Leukemia		<input type="checkbox"/>	Skin, Malignant Melanoma			

Heart and Blood Vessels

<input type="checkbox"/>	Angina (Chest pain)		<input type="checkbox"/>	Heart attack		<input type="checkbox"/>	Peripheral vascular disease
<input type="checkbox"/>	Cardiomyopathy		<input type="checkbox"/>	Heart valvular disease		<input type="checkbox"/>	Deep vein thrombosis (blood clots)
<input type="checkbox"/>	Congestive heart failure		<input type="checkbox"/>	High blood pressure			
<input type="checkbox"/>	Coronary artery disease		<input type="checkbox"/>	Irregular heartbeat requiring treatment			

Lungs and Respiratory

<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Have you been prescribed Bi-PAP or CPAP for sleep? Yes No
<input type="checkbox"/>	COPD/Emphysema	<input type="checkbox"/>	Pulmonary embolism		
<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Sleep apnea		

Stomach and Digestive

<input type="checkbox"/>	Diverticulosis	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Cirrhosis
<input type="checkbox"/>	Crohn's Disease/Ulcerative colitis	<input type="checkbox"/>	Stomach ulcer		
<input type="checkbox"/>	GERD/Acid reflux	<input type="checkbox"/>	Pancreatitis		

Bones, Joints, and Muscles

<input type="checkbox"/>	Arthritis (Osteo)	<input type="checkbox"/>	Osteopenia	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	Arthritis (Rheumatoid)	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Keloid
<input type="checkbox"/>	Gout			<input type="checkbox"/>	Psoriasis

Skin

Brain and Nervous System

<input type="checkbox"/>	Restless leg syndrome	<input type="checkbox"/>	Stoke (CVA)	<input type="checkbox"/>	Multiple sclerosis
<input type="checkbox"/>	Peripheral neuropathy	<input type="checkbox"/>	TIA's (small stroke)		

Mental and Emotional Health

<input type="checkbox"/>	Anorexia/Eating disorder	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Schizophrenia
<input type="checkbox"/>	Bi-polar manic-depressive	<input type="checkbox"/>	Panic attacks		
<input type="checkbox"/>	Sexual abuse		If you have been sexually abused, are you in a safe situation now? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Allergies, Immune/Autoimmune

Endocrine

<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Anaphylaxis	<input type="checkbox"/>	Scleroderma
<input type="checkbox"/>	Hypothyroid	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	Thyroid nodule	<input type="checkbox"/>	Fibromyalgia		

Problems with Anesthesia

<input type="checkbox"/>	Hyperthermia	<input type="checkbox"/>	Excessive nausea	<input type="checkbox"/>	Other:
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Serious Injury

<input type="checkbox"/>	Concussion	<input type="checkbox"/>	Other:
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Tests and Immunizations (Please date your *most recent* of the following to the best of your ability)

<input type="checkbox"/>	Influenza Vaccination	Date:
<input type="checkbox"/>	Mammogram	Date:
<input type="checkbox"/>	Pap Test	Date:
<input type="checkbox"/>	Colonoscopy	Date:

Surgeries/Year of Surgery

If there are any additional surgeries that are not listed below, please ensure to list them in the "Other" boxes.

<input type="checkbox"/>	Tonsillectomy Year:	<input type="checkbox"/>	Cataract removal Side: R L Bilateral Year:	<input type="checkbox"/>	Brain Year: What type?
<input type="checkbox"/>	Gallbladder Year: Laparoscopic OR Open technique (circle one)	<input type="checkbox"/>	Appendectomy Year:	<input type="checkbox"/>	Sinuses Year: What type?
<input type="checkbox"/>	Ear Year: What type?	<input type="checkbox"/>	Thyroid removal Year: Total OR Partial (circle one) Left OR Right (circle one)	<input type="checkbox"/>	Lung Year: For what? What type?
<input type="checkbox"/>	Breast Side: R L Bilateral Year: What type?	<input type="checkbox"/>	Hysterectomy Year: Vaginal OR Abdominal (circle one) Ovaries retained: Yes No	<input type="checkbox"/>	Joints Year:
<input type="checkbox"/>	Bypass surgery of the heart arteries Year:	<input type="checkbox"/>	Heart valves Year:	<input type="checkbox"/>	Other: Type: Year:
<input type="checkbox"/>	Spine Year: What type?	<input type="checkbox"/>	Prostate Year:	<input type="checkbox"/>	Other: Type: Year:

Family Cancer History

Please indicate with an X for family members who have had any of the following conditions:

Please ensure to indicate if the family member's relationship was Maternal or Paternal, and include their age at diagnosis.

Family Member	Alive?	Age at Diagnosis /Age at Death	Medical Condition							
			Breast Cancer	Colon Cancer	Melanoma	Ovarian Cancer	Cervical Cancer	Prostate Cancer	Pancreatic Cancer	Kidney Cancer
Sons:	Yes No									
Daughters:	Yes No									
Father	Yes No									
Mother	Yes No									
Brothers:	Yes No									
Sisters:	Yes No									
Aunts:	Yes No									
Uncles:	Yes No									
Paternal Grandparents	Yes No									
Maternal Grandparents	Yes No									

Have you or any member of your family ever been tested for hereditary risk of cancer? Yes No

If yes, please explain: _____

Review of Symptoms

Please an "X" by any current problems you have as listed below. Thank you.

Constitutional

- _____ Decreased energy
- _____ Fever/chills
- _____ Unexplained weight gain
- _____ Unexplained weight loss

Eyes

- _____ Vision changes not corrected by glasses/contacts

Ears

- _____ Dizziness
- _____ Hearing loss
- _____ Ringing in ears

Nose

- _____ Nosebleeds, frequent

Mouth

- _____ Gums in poor condition
- _____ Teeth in poor condition

Cardiovascular

- _____ Chest pain/discomfort
- _____ Irregular heart beat

Respiratory

- _____ Cough, non-productive
- _____ Cough, productive
- _____ Shortness of breath/difficulty breathing

Neurological

- _____ Difficulty remembering
- _____ Difficulty with coordination
- _____ Headaches
- _____ Numbness
- _____ Seizures

Allergic/Immunologic

- _____ Seasonal rhinitis (runny nose)

Social History

Occupation: _____

Tobacco Use:

Cigarettes: Never _____ Quit: Date ____/____/____

Current: Packs per day _____ Date started: ____/____/____

Alcohol Use:

- Do you drink alcohol? Yes No
- _____ Less than 12 drinks per year
 - _____ 1-13 drinks per month
 - _____ 4-14 drinks per week
 - _____ Greater than 2 drinks per day

Gastrointestinal

- _____ Abdominal pain
- _____ Blood in stool
- _____ Diarrhea
- _____ Nausea
- _____ Vomiting

Genitourinary

- _____ Decreased interest in sex/decreased sexual drive
- _____ Unusual menstrual bleeding
- _____ Painful sex
- _____ Vaginal dryness
- _____ Blood in urine
- _____ Difficulty holding urine

Musculoskeletal

- _____ Painful joints
- _____ Pain when using muscles

Skin & Breast

- _____ Discharge from nipple
- _____ Breast masses or lumps
- _____ Breast pain
- _____ Skin rash

Hematologic/Lymphatic

- _____ Bleeds excessively after injury or minor surgery
- _____ Bruises easily
- _____ Masses/lumps in armpit
- _____ Masses/lumps in groin
- _____ Masses/lumps in neck

Psychological

- _____ Feels nervous/anxiety
- _____ Feels sad more than usual (depressed)
- _____ Trouble sleeping

Marital Status:

- _____ Single _____ Married
- _____ Divorced _____ Widowed _____ Separated

Caffeine Intake: (tea, chocolate, soda, coffee, etc.)

- _____ None
- _____ About 1 caffeinated product per day
- _____ About 2-3 caffeinated products per day
- _____ 4 or more products per day

Special Interests: _____

Risk Assessment:

1. How old were you when you had your first menstrual cycle? _____
2. Do you still get your period? _____
3. How many pregnancies have you had? _____ How many live births? _____
4. How old were you when you had your first child? _____
5. Did you breast feed? _____ How many months did you breast feed each child? _____
6. Have you had any breast biopsies? _____ When? _____ On which breast? _____
7. Did your biopsy come back "atypia"? _____
8. Has anyone in your family had breast cancer? If so, what was their age at diagnosis and were they on Maternal or Paternal side? _____
9. Has anyone in your family had ovarian cancer? If so, what was their age at diagnosis and were they on Maternal or Paternal side? _____
10. In the past have you used any hormones? _____ If so, what type and for how long? _____
11. Are you currently using any hormones? _____ If so, what type and how long have you been using them? _____

HYSTERECTOMY

1. Have you had a total hysterectomy with BSO (bilateral salpingo-oophorectomy)? _____
Date: _____
2. Have you had your entire uterus removed? _____ Date: _____
3. Did you have just your left ovary removed? _____ Date: _____
4. Did you have just your right ovary removed? _____ Date: _____
5. Other ovary surgery? _____
6. Other uterine surgery? _____