KENOSHA RADIOLOGY CENTER

BREAST IMAGING HISTORY - MAMMOGRAPHY

PATIENT TO COMPLETE

Name: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____ State: __ Zip: _____

Home Phone: _____ Work: _____

Primary Physician: _____

PREVIOUS MAMMOGRAM

Where/When: _____

FAMILY HISTORY OF BREAST CANCER? ☐No ☐Yes

Who: _____ Age: _____

PERSONAL HISTORY

Breast Cancer: ☐No ☐Yes

Other Cancer: ☐No ☐Yes Type: _____

HORMONE HISTORY, IF ANY

Type: _____ Age: __ to ____ Duration: _____

BIRTH CONTROL PILLS

Age: ___ to ____ Duration: _____

AGE OF FIRST MENSTRAL PERIOD? _____

IF PERIODS STOPPED – AGE? _____

HYSTERECTOMY/OVARIES AGE? _____

PREGNANCY: Age of first live birth: _____

Number of pregnancies: _____

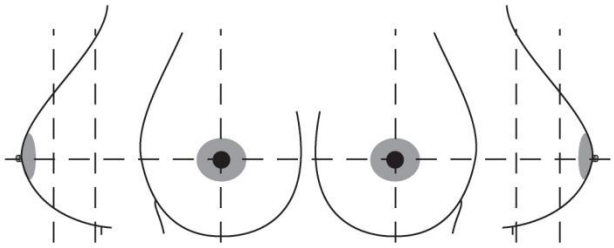
Number of children: _____

Any chance of pregnancy? ☐No ☐Yes

TECHNOLOGIST TO COMPLETE

Date: _____ Tech I: _____ Tech II: _____

MR#: _____ HT:_____ WT:_____



Right Left

Moles O Scar ⫼ Lump X

EXAM TYPE: ☐**DIAGNOSTIC** ☐**SCREENING**

	SIDE/YRS		SIDE/YRS
CORE BIOPSY	_____	CHEMO	_____
LUMPECTOMY	_____	RADIATION	_____
MASTECTOMY	_____	IMPLANTS	_____
SURG. BIOPSY	_____	REDUCTION	_____

CYST ASPIRATION _____

CURRENT PROBLEM? _____

_____

_____

_____

LMP: _____ BCR: _____

Do you use an insulin pump? ☐No ☐Yes

Breast exam by: ☐Physician ☐Nurse

Chambers 1 2 3 4 5 Mode: _____

Density: _____ Number of films: _____

Technologist Signature: _____

Have you been tested for the BRCA1 or BRCA2 gene or received a diagnosis of a genetic syndrome that may be associated with an elevated risk of breast cancer? ☐No ☐Yes

Patient Signature: _____

PATIENT MEDICAL INSURANCE DISCLOSURE FORM – A

DISCLOSURE STATEMENT FOR MEDICAL INSURANCE MEDICAL NECESSITY DENIALS

Notice to:_____
(Patient's Name)

Medical insurance will only pay for services that it determines to be "reasonable and necessary under section 1862 (a)(1) of the Medicare law." If my medical insurance determines that a particular service, although it would be otherwise covered; is "not reasonable and necessary" under medical insurance standards, medical insurance will deny payment for that service. My medical insurance will be billed first, and private insurance second, charges for:

76092	Screening Mammogram and KRC Radiologist Interpretation
(CPT/HCPCS code)	(Description of Service)

Because medical insurance may not consider it medically necessary for the symptoms presented. This means that you may be held responsible for the services mentioned above.

Services provided on: _____
(Date)

Reason medical insurance will not make payment:

ANSI CODE # 119 Benefit maximum for this time period has been reached.

I have been notified by Kenosha Radiology Center that my insurance is likely to deny payment for a screening mammogram if I had one during the last 12-months. If medical insurance denies payment, I agree to be personally and fully responsible for payment.

PATIENT AGREEMENT

I have been notified by Kenosha Radiology Center that should my medical insurance deny payment for the service identified above, I agree to be personally and fully responsible for payment.

_____ _____
Patient Signature (required) Date:

PATIENT MEDICARE INSURANCE DISCLOSURE FORM – B

DISCLOSURE STATEMENT FOR MEDICARE INSURANCE MEDICAL NECESSITY DENIALS

Notice to:_____
(Patient's Name)

Medicare will only pay for services that it determines to be "reasonable and necessary under section 1862 (a)(1) of the Medicare law." If Medicare determines that a particular service, although it would be otherwise covered; is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. Medicare will be billed first, and private insurance second, charges for:

76092	Screening Mammogram and KRC Radiologist Interpretation
(CPT/HCPCS code)	(Description of Service)

Because Medicare may not consider it medically necessary for the symptoms presented. This means that you may be held responsible for the services mentioned above.

Services provided on: _____
(Date)

Reason Medicare will not make payment:

ANSI CODE # 119 Benefit maximum for this time period has been reached.

I have been notified by Kenosha Radiology Center that Medicare is likely to deny payment for a screening mammogram if I had one during the last 12-months. If Medicare denies payment, I agree to be personally and fully responsible for payment.

PATIENT AGREEMENT

I have been notified by Kenosha Radiology Center that should Medicare deny payment for the service identified above, I agree to be personally and fully responsible for payment.

_____ _____
Patient Signature (required) Date:

KENOSHA RADIOLOGY CENTER
10117 74TH STREET KENOSHA, WI 53142 (262) 697-7770 INFO@KENOSHARAD.COM