Redeemer Health
45 2nd Street Pike Suite 100, Southampton, PA 18966
3300 Tillman Drive Bensalem, PA 19020

Tel: (215) 633-3456 • Fax: (215) 396-3456 • www.comprehensivebreastcare.com
www.holyredeemer.com

STACY L. KRISHER, M.D., FACS • ANNA MAZOR, DO • MALINI IYER, M.D, M.S.,FRCS, FACS
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WEAR A MASK, COME ALONE, CALL UPON ARRIVAL _____

Dear Patient,

Thank you for trusting your care to Comprehensive Breast Care Surgeons.

Your appointment is with _____

Scheduled on _____

At the _____ office.

Please arrive for check in by _____.

Arrival for new patients must be 30 minutes prior to scheduled visit time.

All paperwork must be completed prior to checking in at the front desk.

What is needed for your first visit:

- 2 years of previous breast imaging on X-ray films or CD from any facility outside of Holy Redeemer Health Care
- Written reports that correspond with images.
- Any previous pathology reports involving Breast Cancer.
- Insurance cards
- Photo ID/ Driver's license
- Medication list.

If your insurance requires a referral for a specialist visit this may be ordered by you through your primary care physician – *NPI # 1043401748*.

Please be aware that if you arrive late, without studies or a referral you will be subject to reschedule your appointment.

If you are already a patient with Holy Redeemer Physicians it will not be necessary to bring films or reports.

Thank you for your attention to details.

Front Office Staff

Patient Name _____Date of Birth_____

BREAST RISK ASSESSMENT

Age: _____ Race: _____ Allergies: _____Latex? ____

Menarche (age of first period): _____

How old you were when you had your first child? _____

Number of parents/siblings or children with breast cancer diagnosed: _____

Have you had a breast biopsy previously? How many and when? _____

Were there atypical/precancerous cells on the biopsy? Yes _____No _____

Gynecologic History # pregnancies: _____ # live births ___ # Miscarriages_____

What was the first day of your last period _____ or, your age at menopause _____

Were your children breast fed? Yes ___No ___

Did you use birth control pills? Yes ___No ___ # of years_____

Did you use hormone replacement? Yes ___No____# of years_____

Did you use fertility meds/treatment? Yes ____No____

Are you of Ashkenazi **Jewish** descent? Circle ----Yes or No

Do you have a personal history of cancer? If yes what? _____

_____

Have you had prior radiation treatments? _____

Our current guidelines at Holy Redeemer allow for us to offer you a chaperone during your clinical breast exam if desired. Would you prefer that a staff member stand in with you and the provider during this exam? YES or NO

Patient Medical History Sheet

Patient Name: _____ Date of Birth:_____ Date: _____

Occupation: _____ Allergies:_____

MEDICAL HISTORY-Check (X) where appropriate

YOU	RELATIVE		YOU	RELATIVE	
_____	_____	Diabetes Mellitus	_____	_____	Reflux/Hiatal Hernia
_____	_____	Migraines/Headaches	_____	_____	Swallowing/Esophageal Problems
_____	_____	High Cholesterol/Triglycerides	_____	_____	Glaucoma/Vision Problems
_____	_____	High Blood Pressure	_____	_____	Seizures
_____	_____	Heart Disease/Attack	_____	_____	AIDS/HIV
_____	_____	Heart Failure/Valve	_____	_____	Liver Problems
_____	_____	Hearing Problems/Loss	_____	_____	Hepatitis/Cirrhosis
_____	_____	Cancer type -if yes fill out breast assessment	_____	_____	Stomach Ulcers/Gastritis
			_____	_____	Arthritis
_____	_____	Lung Disease	_____	_____	Rheumatoid/Lupus/Gout
_____	_____	Sleep Apnea	_____	_____	Osteoarthritis
_____	_____	Empysema/COPD	_____	_____	Thyroid Problems
_____	_____	Asthma	_____	_____	Skin Diseases
_____	_____	TB/PPD	_____	_____	Clotting/Bleeding disorders
_____	_____	Orthopedic Problems	_____	_____	Kidney Problems/Stones
_____	_____	Colitis	_____	_____	Depression/ Anxiety
_____	_____	Vascular disease(Aneurysm)	_____	_____	Anemia(Iron,B12)
_____	_____	Neuromuscular/MS	_____	_____	Other: _____

Please explain which relative below:

_____

_____

_____

SURGICAL HISTORY: Please list all surgeries and dates(if possible)

_____

_____

_____

MEDICATION AND DOSAGE: (Prescription, over the counter,vitamins, etc)

_____

_____

_____

SOCIAL HISTORY: Check (X) where appropriate

__ Tobacco __ How many packs/day? __ How many years?

_____ Alcohol _____ How many drinks per week?

_____ Drugs /Substance abuse? _____

_____ Coffee or tea _____ How many cups/day

___Have you ever had a blood transfusion?

___ Do you exercise regularly?

___Are you on a special diet?

_____ Are you in a relationship where you have been physically hurt?

Name: _____ Date: _____

REVIEW OF SYSTEMS For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while. Please check no problems if no issues in each category.

Constitutional: ❑ No Problems
- ❑weight gain
- ❑weight loss
- ❑fever
- ❑night sweats.

Eyes: ❑ No Problems
- ❑ Significant Vision change
- ❑eye irritation
- ❑eye disease or injury

Ears, Nose, Mouth & Throat: ❑No Problems
- ❑Difficulty with hearing
- ❑Sinus problems
- ❑Frequent nosebleeds
- ❑ Bleeding gums

C-V (Heart & Blood Vessels): ❑ No Problems
- ❑ Chest Pain
- ❑Shortness of breath with exertion
- ❑irregular heart beat/palpitation
- ❑ Heart murmur
- ❑ Ankle Swelling

Lungs: ❑ No Problems
- ❑Shortness of breath
- ❑Cough
- ❑Coughing up blood
- ❑Sleep Apnea

GI (Stomach & Intestines): ❑ No Problems
- ❑Abdominal pain
- ❑Constipation
- ❑Diarrhea
- ❑Nausea
- ❑Vomiting
- ❑Loss of Appetite

GU (Kidney & Bladder): ❑ No Problems
- ❑Frequent urination
- ❑Incontinence

MS (Muscles, Bones, Joints): ❑ No Problems
- ❑ Aching muscles
- ❑Muscle weakness
- ❑Joint pain
- ❑Back pain
- ❑Swelling in extremities
- ❑Neck pain
- ❑Difficulty walking

Integ. (Skin, Hair & Breast): ❑ No Problems
- ❑Abnormal mole/skin lesion
- ❑Jaundice
- ❑Rash
- ❑Breast mass

Neurologic (Brain & Nerves) : ❑ No Problems
- ❑ Seizure
- ❑ Dizziness
- ❑Headaches

Psychiatric (Mood & Thinking): ❑ No Problems
- ❑ Depression
- ❑Feel unsafe in relationship
- ❑Anxiety

Endocrine: ❑ No Problems
- ❑ Fatigue

Hematologic (Blood/Lymph): ❑ No Problems
- ❑Swollen glands/lymph nodes
- ❑Easy bleeding
- ❑Easy bruising
- ❑ Anemia

Allergic/Immunologic ❑ No Problems
- ❑ Itching
- ❑ Hives

Other:

_____

_____

_____

Cancer Family History Questionnaire

PERSONAL INFORMATION

Patient Name		Date of Birth	Age
Gender (M/F)	Today's Date (MM/DD/YY)	Health Care Provider	

Please mark below if there is a personal or family history of any of the following cancers. If yes, then indicate family relationship and age at diagnosis in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, cousins, great-grandparents, nieces, nephews, half-siblings, grandchildren.

CANCER	YOU	Age of Diagnosis	SIBLINGS/ CHILDREN	Age of Diagnosis	MOTHER'S SIDE	Age of Diagnosis	FATHER'S SIDE	Age of Diagnosis
For example: Colon/rectal cancer	*None*	------	*Brother*	*36 yrs*	*Aunt/Cousin*	*44 yrs 58 yrs*	*Grandfather*	*65 yrs*
BREAST AND OVARIAN CANCER								
Breast Cancer *(Male or Female)*								
Ovarian Cancer								
Breast cancer in both breasts OR multiple primary breast cancers								
Male Breast Cancer								
Pancreatic cancer								
Prostate cancer* *(*Gleason Score≥7)*								

Are you of Ashkenazi Jewish descent? ○ YES ○ NO

COLON AND ENDOMETRIAL CANCER								
Endometrial *(Uterine)* cancer								
Colon/rectal cancer								
Stomach (*Gastric*)/Small bowel cancer								
Kidney, urinary tract, biliary tract cancer								
10 or more lifetime colon/rectal polyps *(specify #)*								

OTHER CANCER (*specify cancer type*) _____

Have your or anyone in your family had genetic testing for a hereditary cancer syndrome?
If Yes, Who?_____What gene(s)?_____What was the result? _____

CANCER RISK ASSESSMENT REVIEW (To be completed after discussion with your healthcare provider)

Patient's Signature _____ Date _____

Health Care Provider's Signature _____ Date _____

Office Use Only

Patient offered hereditary cancer genetic testing? ○ YES ○ NO ○ ACCEPTED ○ DECLINED

If Yes, which test? ○ BRAC*Analysis*® with Myriad myRisk® ○ Multisite 3 BRAC*Analysis* REFLEX to BRAC*Analysis* with Myriad myRisk

○ COLARIS®PLUS with Myriad myRisk ○ COLARIS *AP*®PLUS with Myriad myRisk ○ Single Site Testing ○ Myriad myRisk Update

Other: _____

Follow-up appointment scheduled: YES NO Date of Next Appointment: _____

myriad

HR PHYSICIAN SERVICES
PATIENT INFORMATION PLEASE PRINT

Patient Name: _____ Previous Name: _____ DOB _____
Address: _____ City, State: _____ Zip: _____
Home Phone: _____ Cell: _____ Work Phone: _____

Gender: Male _____ Female _____ Transgender _____ Patient declines to provide: _____

Social Security Number: _____

Primary Care Provider (MD, DO, CRNP): _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Name of PCP who referred you: _____
(If applicable)

Emergency Contact: Name: _____ Address: _____
Phone: _____ Relationship: _____

Responsible Party: Self _____ OR Name: _____ Relationship: _____ DOB: _____
Address: _____ City, State: _____ Zip: _____

Policy Holder/Subscriber: Self _____ OR Name: _____ DOB: _____
SS#: _____ Address: _____ City, State: _____
Zipcode: _____ Phone: _____

Primary Insurance: Company: _____ Address: _____
City/State: _____ Zip: _____ Phone: _____
ID# _____ Group# _____

Secondary Insurance: Company: _____ Address: _____
City/State: _____ Zip: _____ Phone: _____
ID# _____ Group# _____

Employer Name: _____ Phone: _____
Address: _____ City, State: _____ Zip: _____

HR PHYSICIAN SERVICES
PATIENT INFORMATION PLEASE PRINT

Email address: Enter Email address below:

_____

I do not have an email address _____

Permission to leave message: (*Check all that are permitted*):

Home: ___ Cell ___ Work ___

Language: *Check one (Optional)*

English _____ Other: _____ Patient declines to provide: _____

Race: *Check one (Optional)*

American Indian ___ Alaska Native ___ Asian ___

Black or African American ___ Native Hawaiian or Other Pacific Islander

White _____ Patient declines to provide

Ethnicity: *Check one (Optional)*:

Hispanic or Latino _____ Not Hispanic or Latino ___ Patient declines to provide: _____

Local Pharmacy:	**Mail-In Pharmacy:**
Name: _____	Name: _____
Address: _____	Address: _____
City/State: _____	City/State: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

I verify that my information is correct by my signature below.

Signature (Patient/Responsible Party): **Date:**

_____ _____

HR PHYSICIAN SERVICES

Permission to Speak to another Individual
Regarding your Medical Care

Patient Name: _____ Date of Birth_____

I authorize my doctor(s) and/or staff to share my personal health information with the person(s) listed below. This person(s) may have access to, receive copies of, and discuss my health information and medical care with my doctor(s) and their staff.

Name:_____

Relationship: _____

Name: _____

Relationship: _____

Name:_____

Relationship: _____

_____ _____

Signature of Patient or Legal Guardian Date

9/2018

HR PHYSICIAN SERVICES
CONSENT FOR FINANCIAL RESPONSIBILITY

Patient Name: _____
[Please Print]

I hereby assign payment of my medical insurance benefit directly to HR Physician Services for services provided. I understand that I will be financially responsible for any patient balance due under the following provisions:

Co-Pay Due/Deductible Not Met/Co-insurance Due

I understand that I will be financially responsible for all co-pays due for services provided or if my deductible has not yet been met or if there is a co-insurance due.

Non-Covered Services

I agree to be responsible for any professional charges incurred for a non-covered service for which my health plan will not make payment.

Enrollment Not in Effect/No Health Insurance

I understand that I will be financially responsible for all professional charges incurred if service was provided when my enrollment in a health plan was not in effect or if I have no health insurance.

_____ _____
Patient's Signature (Parent or Guardian if Patient is a Minor) Date

HR PHYSICIAN SERVICES
GENERAL CONSENT TO TREATMENT

I hereby authorize HR Physician Services, its physicians, nurse practitioners and staff to provide examinations, and/or evaluations, treatments, etc. as deemed necessary and in accordance with sound medical procedures. I hereby consent to such treatment and procedures with the understanding that treatment and procedures that involve significant risk will not be performed without my prior, specific informed consent.

I understand that as a part of the provision of my healthcare services by HR Physician Services, health information is collected, compiled, and maintained in my medical record. This information includes a description of my health history, physical examinations, test results, surgical reports, pathology and other laboratory reports, medications, treatment plans, and communications among the healthcare staff.

I authorize HR Physician Services to obtain and use the external prescription history via the RxHub service. This provides prescribing history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers for treatment purposes.

I understand that this information is used as a source for my treatment and care, for preparation of my bill, for verification by my insurance carrier or third-party payer that services were billed correctly, and for routine healthcare operations of the facility such as conducting planning and auditing functions.

I acknowledge that I have received a copy of HR Physician Services Notice of Privacy Practices that provides a more complete description of uses and disclosures of my health information and understand that I have the right to review this Notice prior to signing this consent.

I understand that I have the right to revoke this consent in writing except to the extent that HR Physician Services has already taken action in reliance on the consent.

The undersigned certifies that he/she has read the above and is the patient, parent, guardian or representative authorized to execute the above and accept its terms.

_____ _____

Signature of Patient (or Person authorized to consent for Patient) Date

_____

Relationship to Patient of Authorized Person

Effective 9/2018

HR Physician Services
NOTICE OF PRIVACY PRACTICES

Revision Date: April 23, 2021

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.**

If you have any questions about this notice, please contact our Privacy Officer at (215) 856-1148.

At HR Physician Services ("HRPS"), an affiliate of Redeemer Health, we respect the privacy of your health information and are committed to maintaining our patients' confidentiality. This Notice describes your rights and our obligations as required by the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act (collectively referred to as HIPAA) regarding your health information and informs you about the possible uses and disclosures of your health information. This Notice applies to all information and records related to your care that HRPS has received or created, or will receive or create. It extends to information received or created by our employees, staff, and volunteers as well as by doctors and/or other health care practitioners practicing at HRPS.

This notice applies to all HRPS' office facilities and programs that may share information as necessary to coordinate your care and for purposes described in this Notice

Uses and Disclosures Without Authorization: HRPS may use and disclosure your health information for purposes of treatment, payment, and health care operations as described below.

- **For Treatment**: Health care professionals, such as physicians and other health care practitioners within HRPS may access your information for the purpose of providing care to you. We may also share information with providers who will care for you in other settings such as a hospital.
- **For Payment:** We may use and disclose your health information so that we can bill and receive payment for the treatment and services you receive.
- **For Health Care Operations:** We may use and disclose your health information as necessary for facility operations, such as for management purposes, or the monitoring of the quality of care you receive from HRPS.

Other Uses and Disclosures That May Be Made Without Written Authorization, Unless You Object

- **Individuals Involved in Your Care:** Unless you object we may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- **Future Communications:** We may communicate to you via newsletters or other means regarding treatment options, disease-management programs, wellness programs, or other community based initiatives our facility is participating in. If you do not wish to be contacted please let us know by calling 1-800-818-4747.
- **Fundraising Activities:** We may use certain health information to contact you in an effort to raise funds for HRPS. If you do not wish to be contacted please let us know by calling 1-800-818-4747.
- **Appointment Reminders** We may use or disclose health information to remind you about appointments.
- **Business Associates:** There are some services provided in our organization through contracts with independent contractors who, for the purposes of HIPAA, are considered HRPS's "Business Associates".
- **Participation in an HIO** – We participate with one or more secure health information organization networks (each, an "HIO"), including an HIO called "HealthShare Exchange of Southeastern Pennsylvania, Inc., ("HSX"), which makes it possible for us to share your health information electronically through a secure connected network. We may share or disclose your health information to HSX and other secure HIOs, including HIOs contracted with the Commonwealth of Pennsylvania, and even HIOs in other states. Other health care providers, including physicians, hospitals and other health care facilities, that are also connected to the same HIO network as us can access your health information for treatment, payment and other authorized purposes, to the extent permitted by law. You have the right to "opt-out" or decline to participate in HSX and other HIOs. To opt out of HSX, go to: https://www.hsxsepa.org/patient-options-opt-out-back

Other Uses and Disclosures That May Be Made Without Written Authorization: HRPS is permitted and may be required to use or disclose your health information without your written authorization in limited situations. The following lists the limited situations in which HRPS may use and disclose your health information without written authorization. If you have further questions about these instances please contact the Privacy Officer at (215) 856-1148.

- As required by law
- Food and Drug Administration if necessary to report product defects or participate in product recalls
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Reporting Victims of Abuse, Neglect or Domestic Violence
- Judicial and Administrative Proceedings
- Law Enforcement

- Correctional Institutions if you are an inmate
- Workers Compensation Agents for care provided for work-related injuries or illness
- Military Command Authorities if required for government functions
- Health Oversight Agencies as required to comply with government health care programs
- Funeral Directors, Coroners, Medical Examiners, and Organ and Tissue Procurement Organizations
- National Security and Intelligence Agencies; Protective Services for the President and Others
- Research
- To prevent a serious threat to health or safety
- Immunizations to schools required to obtain proof of immunization prior to admitting the student, as long as we have the student's parent or legal representative's agreement

If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Authorization is Required For All Other Uses of Health Information, unless otherwise now or hereafter permitted by the HIPAA or other applicable Federal, State or Local law, rule or regulation. You may revoke an Authorization to use or disclose health information, in writing, at any time. If you revoke an Authorization, we will no longer use or disclose your health information for the purposes covered by that Authorization, except where we have already relied on the Authorization.

Most uses and disclosures of psychotherapy notes, uses and disclosures of Protected Health Information for marketing purposes, and disclosures that constitute a sale of Protected Health Information require an authorization.

Your Health Information Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, under the Privacy Rule you have the right to:

- **Inspect and Copy:** You have the right to inspect and obtain a paper or electronic (if record is maintained in an electronic format) copy of certain health information. We may charge you a reasonable cost-based fee.
- **Amend:** You have the right to request we amend your health information that is incorrect or incomplete. We are not required to comply with your request. We will include in your record a document you prepare indicating you disagree with or are clarifying your health record.
- **Confidential Communication** You have the right to request we communicate with you through confidential means, on paper or electronically, or at an alternate location or phone number.
- **An Accounting of Disclosures:** You have the right to request a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why. We do not have to account for disclosures for treatment, payment, health care operations, and certain other disclosures (such as those you asked us to make).
- **Right to Receive Notice of a Breach.** You have the right to be notified promptly if a breach occurs that may have compromised the privacy and security of your information.
- **Right to Request Restrictions to a Health Plan.** If you paid out-of-pocket, in full, for a specific item or service received you have the right to request a restriction on disclosure to your health plan with respect to that item or service.
- **Request Restrictions:** You have the right to request a restriction on the uses and disclosure of your health information. We are not required to comply with your request.
- **A Copy of This Notice:** You have the right to a paper or electronic copy of this notice.
- **Complaints** – If you feel we have violated your privacy rights you may contact our Privacy Officer at Holy Redeemer Health System, 521 Moredon Rd. Huntingdon Valley, PA 19006, or by email to sglogowski@holyredeemer.com or by calling 215-856-1148. You may also file a complaint in writing with the Secretary of the Department of Health and Human Services Office for Civil Rights, 200 Independence Avenue, S.W. Washington, D.C. 20201, or by calling 1-877-696-6775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- **We will not retaliate against you for filing a compliant**

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We are required to comply with this Notice.
- We are required to provide you a copy of this Notice.
- We reserve the right to change this notice at any time. The changes will apply to all information we have about you. The current notice will be posted in all HRPS facilities and include the effective date. If the Notice has been materially revised since your last encounter we will offer you a copy of the updated Notice.

Holy Redeemer Health System complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-215-947-3000 (TTY: 1-800-654-5988).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-215-947-3000 (TTY：1-800-654-5988).