HIPAA CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Private Practices: You have the right to read our Notice of Private Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. Please read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact person: CATHERINE TATE,PRESIDENT Telephone:[209]952-9300 Fax:[209]952-9191 Address: 3031 W. March Lane #336E Stockton, Ca 95219

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we receive your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____ **(PRINT)**, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal representative's name: _____Relationship to patient: _____
YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

We ask all patients to show their insurance or managed care membership card so that we may make copies of them. We **cannot** render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for the payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections from insurance companies and will credit any such collections to the patient's account.

PAYMENT AUTHORIZATION

I, _____ **(PRINT)**, hereby authorize **TOM H. PIATT, M.D. INC.** to furnish information concerning my present illness. I direct the insurer to pay, without equivocation, directly to the physician, all benefits due him/her as a result of the claim. Although covered by insurance, I am aware that I am personally responsible for all changes. A photostatic copy of this authorization will be as valid as the original.

Signature of Patient: _____ **Date:** _____**TECH:**_____

LAST NAME: _____ FIRST NAME: _____

DOB: _____/_____/_____ SSN#: _____ - _____ -_____

ADDRESS: _____CITY: _____ZIP CODE: _____

TEL: (_____) _____ EMAIL: _____

INSURANCE ID#_____INSURANCE CARRIER_____

PRIMARY INSURED NAME: _____DOB:_____/_____/_____ SSN: _____-_____-_____

REF MD: _____ PREVIOUS BALANCE: _____PT PAID $_____

LOG _____ SC_____ CHARGED _____ BILLED _____ PMT _____

MAMMOGRAPHY QUESTIONAIRE

NAME_____ DATE OF BIRTH: _____/_____/_____ AGE_____

3D SCREENING (77067, 77063) DIAGNOSTIC UNILATERAL (77065, G0279) DIAGNOSTIC BILATERAL (77066, G0279)

BILATERAL W/ IMPLANTS (77066, G0279) 2D SCREENING (77067) BREAST U/S (76641 COMP) BREAST U/S (76642 LIM)

PREVIOUS MAMMOGRAM: YES NO DATE: ____/____/_____ LOCATION: _____

NAME USED AT THAT LOCATION: _____

POST-MENOPAUSAL: YES NO year? _____ DATE OF LAST MENSTRUAL PERIOD: _____/_____/_____

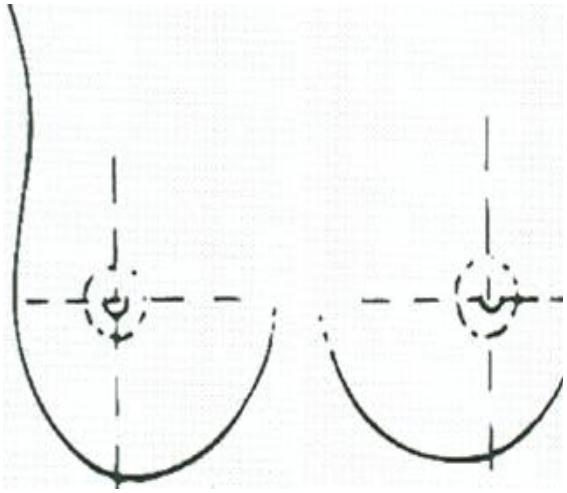
NUMBER OF CHILDREN: _____ AGE AT FIRST PREGNANCY: _____ DID YOU NURSE? YES NO

NEW LUMPS IN BREASTS? Right____ Left____ No____ _____

PAIN OR SORENESS? Right____ Left____ No____ _____

DISCHARGE FROM NIPPLE Right____ Left____ No____ RT LT

DOCTOR FELT LESION ON EXAM? Right____ Left____ No____



TAKE BIRTH CONTROL PILLS? YES_____ NO____

TAKE HORMONES? YES_____ NO____

BRCA GENE 1 OR 2? YES_____ NO____

FAMILY HISTORY OF BREAST CANCER? YES_____ NO_____

CIRCLE: Mother Sister Daughter Grandmother Aunt

Other relative: _____

Pre or post-menopausal? _____

PREVIOUS BREAST CANCER? YES_____ NO_____

PREVIOUS BREAST SURGERY?

RIGHT: YES_____ NO_____ DATE: _____TYPE: _____

LEFT: YES_____ NO_____ DATE: _____TYPE: _____

CIRCLE AS APPROPRIATE:

LUMPECTOMY: R L MASTECTOMY: R L RADIATION THERAPY: R L

CYST ASPIRATION: R L BIOPSY OF BENIGN LESION R L CHEMOTHERAPY R L

BREAST REDUCTION: R L

BREAST IMPLANTS: R L → Silicone or Saline? Pre-pectoral or Post-pectoral?

OTHER: _____

I GIVE MY PERMISSION TO RELEASE MAMMOGRAMS TO: Tom H. Piatt, MD, Inc. / Tate Diagnostic Inc.

PATIENT SIGNATURE_____ DATE: _____/_____/_____