

**Northern Monmouth County Medical Associates
Women's Center - Riverview Medical Center**

1 Riverview Plaza
Red Bank, NJ 07701

**Verification of Billing Information and Consent
Authorization for Billing and Treatment**

Billing Information

- You will receive a bill from Riverview Medical Center for mammography, equipment, technical personnel, etc.
- You will also receive a separate bill from Northern Monmouth County Medical Associates for supervision, interpretation, and performance of examinations.

Insurance Release

I hereby authorize Northern Monmouth County Medical Associates to release any information acquired about me in the course of the medical examination or treatment for insurance filing. Photocopy of this authorization shall be considered as effective and valid as the original.

Medicare Release

I authorize Northern Monmouth County Medical Associates to release any medical or other information about me to Medicare or its intermediaries or carriers required for this or any related Medicare claims. Photocopy of this authorization shall be considered as effective and valid as the original, I hereby request payment of medical benefits to be made either to myself or to the party accepting assignment of this claim.

Patient Signature: _____ Date: _____

THE WOMEN'S CENTER PATIENT HISTORY

Have you had a mammogram before? No Yes - If so, where? _____ When _____
 Are you pregnant? No Yes Have you nursed (breastfed) in the past 6 months? No Yes
 Are you allergic to latex? No Yes Do you have breast implants? No Yes
 Have you lost or gained weight since your last mammogram? No Yes - if yes, _____ lbs lost/gained

Reason for Appointment:

Annual/ Routine Generalized Pain 6 month Follow Up Ultrasound
 Lump Focal Pain Call-Back/Add'l Views Film Consult
 Nipple Retraction/ Inverted Nipples Nipple Discharge – If yes, what color? _____

PERSONAL HISTORY

Have you ever had a needle biopsy, breast reduction, or any other breast surgery? No Yes

Technologist notes: _____

Do you have a personal history of breast cancer? No Yes
 If so when? _____ Which side? _____

Have you received: Radiation Therapy? No Yes Tamoxifen? No Yes
 Chemotherapy? No Yes Arimidex? No Yes

Or other medications related to breast cancer? _____

Do you have a history of any other cancer (especially Ovarian Cancer or Hodgkins Lymphoma)? No Yes
 If so, what? _____

FAMILY HISTORY

Is there a history of breast cancer in your family? No Yes
 Mother At what age? _____ Sister At what age? _____ Other _____ At what age? _____

Your age at the time of your first menstrual cycle? _____ Date of last menstrual cycle? _____

Are you on hormone replacement? No Oral Cream Patch

Age at onset of menopause? _____

Your age at the time of your 1st full term pregnancy? _____

Patient Signature: _____ **Phone #** _____

Technologist Notes: _____

Technologist: _____ Date: _____ Time: _____

Women's Center at Riverview Medical Center

Please note: CD's with prior images may take longer to review due to downloading into Riverview's system.

In addition to the letter that is sent to you, we would like to call you with your mammography results.

May we call you? YES NO

What is the best number to reach you?

_____ CELL or HOME

May we leave you a message with your results?

YES NO

Signature

Date