SOLIS Mammography

Patient Name: _____ Date of Birth:_____

Exam and Billing Notice

***Please initial next** to your applicable examination type*

_____ 3D **SCREENING MAMMOGRAPHY**

This examination is often considered a "routine" examination and may be applied to routine or well-woman benefits. (By opting in, you understand there may be a bill for the 3D portion of mammogram by the hospital and/or the radiologist. The final cost of your mammogram is dependent upon insurance coverage.)

_____ I would like to OPT-OUT of adding 3D/tomosynthesis to my screening mammogram.

_____ **BONE DENSITOMETRY**

Bone Densitometry is a simple scanning test to determine if you have or are at risk for osteoporosis--a disease that causes bone to become more fragile over time. **If there is a patient responsibility after the claim has been processed by your insurance, you will receive a bill from the radiologist and/or the hospital.**

_____ **DIAGNOSTIC BREAST IMAGING**

Diagnostic breast imaging is performed to evaluate potential breast problems. This is to ensure that our radiologists get a clear and accurate picture of your breasts. These exams are **not considered** "routine", "well-woman", or a "screening" to insurance carriers. **If there is a patient responsibility after the claim has been processed by your insurance, you will receive a bill from the radiologist and/or the hospital**

_____ **INSURANCE BILLING** (For Hospital Centers Only)

If there is a patient responsibility after the claim has been processed by your insurance, you could receive a bill. For centers that are a department of the hospital, you may receive a bill for the physician's services as well as a separate bill for
the facility portion from the hospital.

Patient or Representative Signature_____Date_____

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Patient Name: _____ Date of Birth: _____

Authorization for Use or Disclosure of Protected Health Information

Protected Health Information ("PHI") is information about you, including demographic information, that mayidentify you and that relates to your past, present, or future health and related health care services. Consistentwith our Notice of Privacy Practices, Solis Mammography is required to obtain your authorization to permit thefollowing use or disclosure of your PHI for purposes other than treatment, payment and health care operations.Solis Mammography will not condition its provision of services to you on whether you provide authorization for
the requested use or disclosure.

(Check those that apply)
☐ I hereby authorize Solis Mammography to use or disclose the following PHI:

☐ All Procedures
or
☐ Specific Procedures:_____

To the following individuals(include Full Name)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Authorization for Use or Disclosure of Protected Health Information (continued)

I authorize the use or disclosure of the PHI specified above for the following purposes (the statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose):

I understand that I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment, orpayment, or
eligibility for benefits unless: (i) my treatment is related to research and then I will not be permitted to have treatment without signing this Authorization; or (ii) if/when I am receiving health care solely for the purpose of creating PHI for disclosure to a third party on provision of an authorization for the disclosure of the PHI to such third party. I understand that I may inspect or obtain a
copy of the PHI of which I am being asked to allow the use or disclosure. I understand that I have the right to revoke this Authorization at any time by sending such written notification to Solis Mammography Privacy Official via mail to: Solis Mammography, Attn: Privacy Official, 15601 Dallas Parkway, Suite 500, Addison, Texas 75001.Such a revocation will not be effective to the extent that Solis Mammography has relied on it for the previous use or disclosure of the PHI. If I sign this Authorization, I have a right to receive a signed copy of it. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

This Authorization shall be in force and effective for 10 years from the date of my signature or until I revoke or terminate my authorization in writing, whichever is later, at which time Solis Mammography authorization to use or disclose thePHI specified expires.

_____ **Date** _____

Signature of Patient or Representative

If applicable, full name of patient's representative and description of his/her authority to act for the patient:

_____

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Patient Name:_____Date of Birth:_____

Self Pay Waiver

Applicable for Self Pay Patients Only-Please skip to next page if not applicable

You are being provided this letter of acknowledgement because you have requested that your radiology exam today be coded as "self-pay." You have requested that this service be coded as self-pay because **(initial one):**

_____ You have no active health insurance.

_____ You have health insurance, but Solis Mammography is out of network with your plan.

_____ You don't want your claim submitted to insurance due to privacy reason.

We want you to know what to expect so that you can make an informed decision. In order to accomplish this, by signing below, you agree to the following:

• All fees for the self-pay service must be paid in full at the time of service. Please note, additional procedures performed after registration may result in additional fees*.

• Self-pay discount cannot be applied if you have in-network participating insurance coverage, or if you are covered under a Governmental Payer.

• The self-pay amount covers only the services provided by Solis Mammography. You are financially responsible for all ancillary services, for example laboratory and pathology, and you will receive a separate bill from the laboratory or pathology for incurred charges.

• A medical claim will not be submitted to your insurance, even in the event of retro-active insurance coverage.

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions. I confirm that I am the patient, or the patient's duly authorized representative.

Patient or Representative Signature _____Date _____Time _____

If signed by someone other than the patient, please specify relationship to the patient:

_____

For Office Use Only

Exam Performed: _____ Date of Service: _____

*Self-pay *estimate* paid at time of service: _____

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MSP Questionnaire

For Medicare Covered Patients Only-skip to next page if not applicable

Box: 1

Is the patient currently covered under a health plan with their current or previous employer or a family member's health plan? _ Yes or No *(Please Circle or Choose One)* If yes, answer questions in Box 2.
Is the patient's treatment a result of any injury or are they taking Legal action in conjunction with the service to be performed? _ Yes or No *(Please Circle or Choose One)* If yes, answer questions in Box 2
Does the patient have End Stage Renal Disease? _ Yes or No *(Please Circle or Choose One)*
Does the patient have Black Lung Benefits, and if so, is the service to be performed related to Black Lung? _ Yes or No *(Please Circle or Choose One)*

Box: 2

Does the employer have more than 20 employees or multi-employer group with more than 20 employees? Or Is the patient disabled and covered under their current employer or family member's employer's Large Group Health Plan with more than 100 employees or a multi-employer group with more than 100 employees? _ Yes or No *(Please Circle or Choose One)*
Is the injury or illness job-related, auto accident related, or related to any type of liability? _ Yes or No *(Please Circle or Choose One)* If yes which of the following? ☐ The injury is job related. ☐ The injury is auto accident related. ☐ The injury is liability related.

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- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Disclosure to family members, relatives, or personal representatives

- Unless you request limitations, as described in "Your Choices", above, we may disclose your health information to a family member, other relative, close personal friend, or any other individual identified by you. We will limit such disclosures to information directly related to that person's involvement in your health care or payment related to your health care.
- Unless you request limitations, as described in "Your Choices", above, we may use or disclose your health information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, location, or general condition.

Disclosure to business associate

We may share your health information with third party "business associates" that perform certain services (e.g., billing and collections) on our behalf. To protect your health information, however, we require the business associate to agree in writing to appropriately safeguard your information.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your protected health information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your health information other than as described in this Notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind and we will then discontinue such use or disclosure.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website (**www.solismammo.com**). You may also obtain a copy of our most current Notice at your next appointment or you may ask our Privacy Official to send a printed copy to you.

This Notice is effective on September 23, 2013.
Rev. 4.2019

NOTICE OF PRIVACY PRACTICES OF

SOLIS Mammography

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 questions about this Notice, please contact our Privacy Official, Leigh Massey, at 469-398-4134 or leigh.massey@solismammo.com.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee for any requested copies.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we have shared information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, with whom we shared it, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this Notice

You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure that person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting our Privacy Official using the information on page 1 of this Notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not present, or if the opportunity to agree or object to such disclosure cannot practically be provided by you because you are incapacitated or there is an emergency, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with health care professionals who are treating you.
- For example, we will send your radiology report to your treating physician.

Run our organization

- We can use and share your health information to run our organization, improve your care, and contact you when necessary.
- For example, members of our quality improvement team may use information in your health record to assess the services you received from us. This information will then be used in an effort to continually improve the quality and effectiveness of the services we provide.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
- For example, we give information about you to your health insurance plan so it will pay for the services you receive from us.

How else can we use or share your health information?

We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many legal conditions before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share your health information for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if applicable state or federal laws require it, including with the U.S. Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you: