



Jacqueline M. Wilentz Comprehensive Breast Center

Film Consultation / Second Opinion Instructions

Dear Patient,

Thank you for choosing the Jacqueline M. Wilentz Breast Center for your Film Consultation and/or Second Opinion

Film consults are not a scheduled appointment therefore we **can only accept them weekdays from 8:30am – 3:30pm** and **you will be here for approximately 30 minutes**.

To process your film consultation you must provide all required information and documents. If there is information missing your consultation will not be processed until the necessary information is received. Once the radiologist has reviewed your imaging we will contact your referring physician and you with their recommendations. At that time, please contact your referring physician to discuss the recommendations.

1. **Please complete page 1-3**
2. **For Non-Medicare patient, read/review the Waiver Notice and complete outlined section on page 4**
3. **For Medicare patient, ignore page 4, and read/review and complete the ABN form on page 5.**

After reading and completing the above listed forms, provide the receptionist with the following required documents:

1. Prescriptions from your referring physician stating: Film Consultation and/or Second Opinion.
2. Referral from your primary care physician or OBGYN if your insurance company requires one. Contact 800 number listed in your insurance card. (HMO or POS)
3. Insurance Card
4. Form of Identification (ex: drivers license, county ID, voter registration card)

Reminder: You and your physician will receive results and recommendations from our Breast Radiologist within 3 weeks.

Thank you for your cooperation and patience.

Jacqueline M. Wilentz Comprehensive Breast Center Staff
300 Second Avenue, Long Branch, NJ 07740
732-923-7700



Jacqueline M. Wilentz Comprehensive Breast Center

Outside Film Review Form

Please complete page 1 to page 3

Please fill out all questions in bold print only.

Patient Name: _____

Date of Birth: _____

Phone # (please indicate one that is easier for you to be reached)

Home phone number _____

Office phone number _____

Cell phone number _____

Email address: Please indicate if you wish to be reached via email

Email address: _____

Date films (CD) dropped off _____ .

Name of requesting physician _____

Please specify any special request if there is any:

For Breast Center staff:

Please list any specific request per referring physician

Please scan into penrad and as "consult_request_date of request"

Please signed and dated: _____



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Patient Demographic Data Form

PATIENTS LAST NAME: _____ FIRST: _____ M: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME # _____ - _____ - _____ WORK # _____ - _____ - _____ CELL# _____ - _____ - _____

RELIGION: _____ DOB: ____/____/____ SS#: ____/____/____

MARITAL STATUS: S / M / W / D

EMPLOYER'S NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

OCCUPATION: _____ STATUS: FULL / PART / RETIRED: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

TELEPHONE #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY INSURANCE INFORMATION:

INS. CO. NAME: _____ ID#: _____ GROUP#: _____

SUBSCRIBER: _____ DOB: ____/____/____ SS#: ____/____/____

EMPLOYER: _____ WORK#: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

OCCUPATION: _____ LENGTH OF EMPLOYMENT: _____

SECONDARY INSURANCE INFORMATION:

INS. CO. NAME: _____ ID#: _____ GROUP#: _____

SUBSCRIBER: _____ DOB: ____/____/____ SS#: ____/____/____

EMPLOYER: _____ WORK#: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

OCCUPATION: _____ LENGTH OF EMPLOYMENT: _____



(For office use only)

Patient Label

Name: _____

Date of Birth: _____

Last Menstrual Period _____

1st Menstruation : (age) _____

Children birthed _____ (number of children)

1st Full Term Pregnancy : (age) _____

Number of children breast fed; _____

Menopause (circle) Yes / No , if yes, age _____

Hysterectomy Yes / No, If yes, age _____

Ovaries removed Yes / No, if yes, age _____

Smoked Yes/ No, # years smoked _____

Have you ever been pregnant? Yes / No

Last Mammography where _____ when? _____

Hormone / Contraceptives (fill in when it is applicable)

	Starting age	Last used (age)	Duration (Years)
Estrogen	_____	_____	_____
Progesterone	_____	_____	_____
Tamoxifen	_____	_____	_____
Others _____	_____	_____	_____

Risk Factors for Breast Cancer - Please circle yes or no on following:

Other personal cancer history (other than breast; cancer elsewhere) Yes / No

Personal breast cancer history Yes / No

History of gynecological cancer Yes / No

Have you even been told you have following breast condition

LCIS Lobular Carcinoma in Situ) Yes / No

Atypical Hyperplasia Yes / No

Have you had genetic testing Yes / No

If yes, BRCA1 Positive / Negative

BRCA2 Positive / Negative

Use your best judgment to answer following questions (select that all apply)

Family history of breast cancer

Other family members such as Aunt, Cousin or Grandma had history

Post menopause breast cancer history with my mother or sister (cancer was diagnosed after menopause)

Pre menopause breast cancer history with my mother or sister or other first degree relatives (cancer diagnosed prior to menopause)

Breast History

Have you had any breast related surgical procedures? Yes / No ..If yes, please check all that apply

Breast Implant Right _____ Left _____

Breast Reduction Right _____ Left _____

Breast Lift Right _____ Left _____

Breast Biopsy Right _____ Type (please circle one) Sterotactic / Fine Needle/ Ultrasound
guided core biopsy / excision biopsy (in OR)

Left _____ Type (please circle one) Sterotactic / Fine Needle/ Ultrasound

guided core biopsy / excision biopsy (in OR)

Breast Surgery Right _____ Type Lumpectomy / Mastectomy

Left _____ Type Lumpectomy / Mastectomy

Past Breast Cancer treatment Chemotherapy Yes / No

Radiation Yes / No

MONMOUTH MEDICAL CENTER
An affiliate of the Saint Barnabas Health Care System

RONALD J. DEL MAURO
 President and Chief Executive Officer
 Saint Barnabas Health Care System

Waiver Notice

FRANK J. VOZOS, MD, FACS
 Executive Director
 Monmouth Medical Center
 (732) 226-6200
 Fax (732) 592-7511

Thank you for choosing Monmouth Medical Center as your healthcare provider.

Please be advised that the outpatient service(s) you wish to receive may not meet the requirements for coverage as outlined by your insurance carrier. Your insurance company will only pay for covered services according to your insurance plan benefits.

For example, if your insurance carrier requires you to seek services in an outpatient laboratory, (i.e. Quest, Smith Kline) and you elect to have services performed at Monmouth Medical Center, you will be responsible for payment of these services at the time service is rendered. If you have out of network benefits, your insurance carrier may cover a portion of the service(s) rendered.

As per your insurance carrier, the service(s) you are receiving today determine that:

- Services and supplies are considered out of network
- Services and supplies are non-covered under your insurance plan
- Other. Film consultation may not be covered

Please sign below to acknowledge agreement of these terms.

Patient Name: _____

Address: _____

Date of Service: _____

Insurance Company: _____ Identification Number: _____

Patient/Authorized Representative: _____

Date: _____

Witness: _____

Date: _____

Please be advised that if you elect to have the service(s) & refuse to sign this waiver, you will be billed accordingly.

For your convenience, we accept cash, check, Visa, MasterCard, Discover and American Express.

100 SECOND AVENUE ■ LONG BRANCH, NJ 08551-0710 ■ (732) 252-5233

Saint Barnabas Health Care System — New Jersey's multi-care system.



om

Patient's Name: _____

Medicare # (HICN): _____

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these laboratory tests.

We expect that Medicare will not pay for the laboratory test(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, Medicare probably will not pay for the laboratory test(s) indicated below for the following reasons:

Medicare does not pay for these tests for your condition	Medicare does not pay for these tests as often as this (denied as too frequent)	Medicare does not pay for experimental or research use tests
Film Consultation		

The purpose of this form is to help you make an informed choice about whether or not you want to receive these laboratory tests, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these laboratory tests will cost you (Estimated Cost: \$ 125.00) in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.

Option 1. YES. I want to receive these laboratory tests.

I understand that Medicare will not decide whether to pay unless I receive these laboratory tests. Please submit my claim to Medicare. I understand that you may bill me for laboratory tests and that I may have to pay the bill while Medicare is making its decision.

If Medicare does pay, you will refund to me any payments I made to you that are due to me.

If Medicare denies payment, I agree to be personally and fully responsible for payment.

That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

Option 2. NO. I have decided not to receive these laboratory tests.

I will not receive these laboratory tests. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay. I will notify my doctor who ordered these laboratory tests that I did not receive them.

Date _____

Signature of patient or person acting on patient's behalf _____

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OIG Approval No. 0932-0588 Form No. CMS-R-131-L (June 2002)

Jacqueline M. Wilentz Comprehensive Breast Center

Film data sheet by breast center staff only

BC staff (receiver) – please verify the needed CD and/or films are submitted correctly

Date od dropped off (CD/Films) _____ Patient Name: _____

Patient Date of Birth: _____ Patient’s signature _____

Please indicate submitted format(s)

CD **Facility:** _____

Printed Films **Facility:** _____

Year(s): _____

Type of image(s) _____

Each patient needs to submit images along with reports which are consulted and 1-2 years prior for comparison if they are available.

BC staff signature (receiver) and date _____

Comments:

Film library staff – please complete following table and work with technologist to upload the images into PACS accordingly.

Please upload images into PACS per MMC procedure and indicated uploaded data below:
Only upload the image(s) which are consulted for review and 1-2 years prior if they are available. Please indicate if report is available.

Type of image	Date performed	Check if report is available	Comments

Film library staff signature and date _____

Pease scan into penrad as filmdata_date of submission; please scan each available report into penrad per penrad scanned document instruction