

**Breast Center of Central WI**  
413 N. 17th Avenue  
Suite 120  
Wausau, WI 54401  
Phone: 715-848-3700  
Fax: 715-848-7171



**PATIENT REGISTRATION**

**Patient Name (Last):** \_\_\_\_\_ **First:** \_\_\_\_\_ **Init:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Apt #:** \_\_\_\_\_ **City, State & Zip:** \_\_\_\_\_

**Phones:** Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Patient Social Security #:** \_\_\_\_\_ **Male** \_\_\_ **Female** \_\_\_ **Marital Status:** M \_\_\_ S \_\_\_ D \_\_\_ W \_\_\_

**Patient Employer:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Work Status:** \_\_\_\_\_ **Student Status:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Gynecologist:** \_\_\_\_\_

**Responsible Party Name:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Responsible Party Social Security #:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**How will the bill be paid today?** \_\_\_\_\_

**EMERGENCY CONTACT(& Relationship):** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

**Who referred you to Dr. Galloway?** \_\_\_\_\_

**Do you have a living will?** YES NO **Would you like information on a living will?** YES NO

**Primary Insurance Company:** \_\_\_\_\_

**Policy Holder Name:** \_\_\_\_\_ **Policy Holder Date of Birth:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Co-pay:** \_\_\_\_\_ **Deductible:** \_\_\_\_\_

**Effective Date of Coverage:** \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_

**Policy Holder Name:** \_\_\_\_\_ **Policy Holder Date of Birth:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Effective Date of Coverage:** \_\_\_\_\_

I certify that information provided pertaining to my health insurance coverage is true and correct. I authorize that payment for services rendered should be made payable to Pamela G. Galloway, MD. I authorize release of medical information necessary to process this (these) claim(s). I have read all the terms and conditions contained in this agreement and agree to be bound by these terms and conditions.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**INITIAL VISIT QUESTIONNAIRE**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Past Medical History** (Check all that area applicable)

- High blood pressure
- Heart attack
- Angina
- Irregular rhythm
- Heart failure
- Heart valve disease
- High cholesterol
- Peripheral vascular disease
- Stroke
- Seizures
- History of radiation treatment
- Diabetes
- Kidney Disease
- Hepatitis / Liver disease
- Asthma / COPD
- TB
- Blood Clots (DVT or PE)
- Other blood diseases
- History of blood transfusion
- Inflammatory Bowel Disease
- Peptic Ulcer / Gastritis
- Other: \_\_\_\_\_
- Cancer
- Thyroid disease
- Arthritis
- Osteoporosis
- Depression
- Other Psychiatric problems
- Alzheimer's disease
- HIV/AIDS
- Anesthesia problems
- Connective Tissue Diseases

Details: \_\_\_\_\_

**Previous Surgical Procedures (including specifically any breast procedures):**

Procedure	Date

Medications:	Name	Dose	How frequently

Allergies:	Drug	What happens



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Do you smoke? (If so how much): \_\_\_\_\_ Use alcohol?: \_\_\_\_\_

**Breast Cancer Risk Assessment Information:**

Number of pregnancies: \_\_\_\_\_ Deliveries: \_\_\_\_\_ Miscarriages: \_\_\_\_\_

Ectopic: \_\_\_\_\_ Terminations: \_\_\_\_\_

Age that you had your first menstrual period: \_\_\_\_\_ Age at time of first delivery: \_\_\_\_\_

Date (or age) of your last menstrual period: \_\_\_\_\_ Are your menstrual cycles regular? \_\_\_\_\_

Have you used hormone replacement?: YES NO

If so, for how long: \_\_\_\_\_ If you did in the past, when did you stop: \_\_\_\_\_

Details: \_\_\_\_\_

\_\_\_\_\_

Have you used pills or hormone shots for contraception?: YES NO

If so, for how long (or approximate dates): \_\_\_\_\_

**Family history of cancer (A family history of breast or ovarian cancer on either the father's or mother's side is extremely important):**

Relative (indicate maternal or paternal)	Age at diagnosis	Cancer type
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Family history of other diseases: (like high blood pressure, heart disease, diabetes, stroke, etc.)**

Relative	Disease
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Ashkenazi (Eastern European Jewish) ancestry: YES NO

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### **NOTICE OF PRIVACY PRACTICES**

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

**We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.**

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

**Pamela G. Galloway, MD**

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

**I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) I have the right to privacy regarding my protected health information. I understand that this information will be used to carry out treatment, payment and health care operations.**

*I hereby acknowledge that I have been presented with a copy of PAMELA G. GALLOWAY, MD’s Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information and my individual rights with respect to my protected health information.*

**PATIENT NAME:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**OFFICE USE ONLY**

I have attempted to obtain the patient’s signature in acknowledgement of this **Notice of Privacy Practice Acknowledgement**, but was unable to do so as documented below:

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_

PAMELA G. GALLOWAY, MD  
**Breast Center of Central WI**  
413 N. 17th Avenue, Suite 120  
Wausau, WI 54401  
Phone: 715-848-3700



### **Financial Policy**

Welcome to our office! We are pleased that you have chosen us to provide your care and service. We want to take a moment of your time to inform you of our policies regarding payment with our office.

We accept cash, personal checks, Visa and MasterCard for payment on your account. If you have insurance which we do not contract with, you will be expected to make a full or partial payment on the day of your visit. If your insurance is one we do contract with, you are expected to pay your co-pay at the time of your visit.

**COMMERCIAL/PRIVATE INSURANCE:** As a courtesy we will be happy to file your insurance for you. You will be required to provide a copy of your insurance card and all necessary billing information. If you owe on your deductible or owe a co-pay we will need to collect that at the time of service. All insurance payments that are paid directly to you must be endorsed and paid to this office/physician. It is your responsibility to contact your insurance in the event of non-payment or discounted payments. Many private insurance companies in an effort to set physician fees restrict payment indicating that fees are over their "Usual and Customary" fees for this area. We have hired consulting firms to ensure our fees are comparable to that of other offices providing the same quality and level of care. We will not allow insurance companies to set our fees for us, based upon their willingness to pay.

**CONTRACTED INSURANCE:** We will submit a claim directly to the insurance carrier if you provide us with the necessary information. This includes a copy of your insurance card, an address to submit claims to and a telephone number allowing us to verify your coverage. You still are responsible for payment of your co-pay at the time of service and any amounts not covered by your insurance, including deductibles. If coverage is denied for any reason, you are responsible for payment of the entire balance due, based on our normal fee schedule.

\_\_\_\_\_ **In the event Dr. Galloway is not contracted with your health plan, you will be responsible**  
*Initial here* **for any out of network, coinsurance, or deductible applied.**

**NO INSURANCE:** If you do not have insurance, we expect you to pay for your visit at the time of service. In the event of surgery, our Financial Advisor can help answer questions about financial arrangements.

**MEDICARE:** We are participating providers with Medicare. We will submit your claim to your insurance. Medicare will process the payments to us. You are responsible for your deductible and any co-pays/co-insurance at the time of service.

**RETURNED CHECKS:** In the event your bank returns your check to our office unpaid, there will be a \$25.00 return check fee charged to your account.

**NON-PAYMENT:** In the event your account becomes delinquent, you will be responsible not only for charges incurred but also any costs involved in collection on your account. These include but are not limited to interest charges, rebilling fees, court costs, attorney fees, and collections costs. A collection agency may be used to collect on delinquent accounts. Insurance benefits are a matter between you and your insurance company. You are ultimately responsible for the payment on your account.

If you have any questions regarding our payment policies, please ask us before your visit. Thank You!

*I have read and understand the payment policies set forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment of my account with Pamela G. Galloway, MD and have provided to the best of my ability the information requested accurately and completely.*

\_\_\_\_\_  
Patients/Responsible Party Signature

\_\_\_\_\_  
Date



**BREAST CENTER OF CENTRAL WISC., SC  
DISCLOSURE TO FAMILY AUTHORIZATION**

This form is to be used to allow family members, close friends or other persons to be informed about your health information. This form will be effective for the duration of your care or until you provide us with further notice.

Please list the person(s) to whom information about your health care may be disclosed.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Patient Signature:**

I attest that information regarding my care and treatment may be disclosed to the above mentioned person(s) indentified above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**If this form is signed by a person on behalf of the patient, please complete the following:**

Authorized Representative's Name: \_\_\_\_\_

Date: \_\_\_\_\_

This form will be retained in the patient's health information record.