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| PATIENT NAME IN FULL | AGE | DATE | TIME |
|----------------------|-----|------|------|

CONSENT - MAMMOGRAPHY PROCEDURE

➤ I understand that I am at Saint Francis for a mammography procedure. I will not assume that my exam is normal if I should fail to receive my results. **Federal Law now requires that each patient receive written test results in layman's terms.** Please write your mailing address in the space provided:

ADDRESS, CITY, STATE, ZIP

- I understand that mammograms are the best single method for detection of early breast cancer, but that they **DO NOT FIND** all breast cancers. Therefore it is important for me to do a monthly breast self-exam and have an annual physician breast exam.
- I understand that Saint Francis Breast Center personnel will send to my physician(s) a copy of my mammography report and to release information pertaining to this admission to my insurance carrier(s) to determine benefits entitlement and to process payment claims for me.
- Medical information will be retained electronically, with safeguards in place to discourage unauthorized access.
- My insurance company(ies) may pay Saint Francis and physician(s) responsible for my breast care benefits payable to me (benefits are assigned to providers).
- MEDICARE IS IS NOT applicable.
- I certify that the information I have provided is correct. I understand that disclosure of information may be made to the Social Security Administration or its intermediaries or carriers any information needed for this Medicare claim. I request that payment of authorized benefits be made directly to Saint Francis for the undersigned.
- The undersigned is responsible for any noncovered or nonreimbursable services, deductibles and copayments.
- I understand that valuables in my possession are my responsibility, and I will not hold Saint Francis liable for loss of valuables.
- *I understand that release of my mammograms and mammography reports will be made to the representatives or agents of Saint Francis Hospital, Inc., to be used for the purpose of comparison to my current mammogram.*

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

A detail of patient rights and how medical information will be used and disclosed by Saint Francis Hospital and its medical staff is set forth in the NOTICE OF PRIVACY PRACTICES. A copy has been furnished to me.

I have read and understand this consent form. All questions regarding this procedure have been answered to my satisfaction. I acknowledge receipt of NOTICE OF PRIVACY PRACTICES.

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| PATIENT'S SIGNATURE | REASON PATIENT UNABLE TO SIGN |
| SIGNATURE OF PERSON AUTHORIZED TO SIGN FOR PATIENT | |
| RELATIONSHIP TO PATIENT | WITNESS |

TRANSLATION

This is to certify that the above Consent has been provided in printed format or read to the patient (or representative) in his / her native language. The patient (or representative) understood and agreed and was asked to sign the English version (legally valid document) and was shown where to indicate Consent.

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|---------------------------------|----------------------|
| INTERPRETER / WITNESS SIGNATURE | PATIENT LABEL |
|---------------------------------|----------------------|