Mission Regional Medical Center

2015-2016 FREE SCREENING MAMMOGRAPHY DISCLAIMER

Applicants of the free digital screening mammogram agree to all of the following:

The digital screening mammogram must be performed at The Breast Care Center at Mission Regional Medical Center **before August 31, 2016**. Patient is responsible to call The Breast Care Center at (956) 323-1700 to schedule an appointment.

By accepting the free digital mammogram, patient accepts and agrees (1) to be bound by all the rules, limitations and restrictions set forth here and (2) that their names and/or likenesses may be disclosed to and used by the news media and may otherwise may be used by Mission Regional Medical Center for publicity purposes in area newspapers or other media including television, radio, web and print.

ELIGIBILITY:

- Applicant must be a U.S. citizen or legal resident to qualify. *View Page 2 for required Identification Verification items.*
- Applicant must be a current resident of Hidalgo, Starr, Willacy or Cameron County.
- This free mammogram program covers images and radiologist's fees only. It does not cover the fees by the patient's physician or other required additional studies or further interventional procedures.
- Free screening mammogram is offered to uninsured patients over age 40 only. *View Page 2 for required Income Verification documents.*
- Patients over the age of 40 do not need a doctor's referral for mammography.
- Patient must have a local doctor to ensure the results are received by the physician and may be immediately contacted if additional studies or further interventional procedures are required. Results will not be forwarded to physicians in Mexico.
- Patient must have seen their physician in the past year. Physician may be contacted the day of the exam.
- Previous mammogram (if applicable) has to have a negative result.
- This offer does not apply to patients who have had a personal history of breast cancer or breast augmentation.
- The exam is a screening mammogram, meaning asymptomatic (no complaints of pain, lumps, etc.)
- The mammography results will be sent by mail to the patient and by fax to their physician.

Patient Signature _____ Date _____

Printed Name _____

Mission Regional Medical Center

IDENTIFICATION AND INCOME VERIFICATION

All four items below must be attached with your application:

1. PROOF OF LEGAL STATUS IN THE UNITED STATES

Please provide one form of proof of U.S. Legal Status below:

PROOF OF U.S. CITIZENSHIP
- If you were born in the United States, a copy of your birth certificate
- If you were naturalized, a copy of your naturalization certificate
- If you were born outside of the U.S. and you are a U.S. citizen through your parents, provide:
    - Your original Certificate of Citizenship or
    - Your form FS-240 (Report of Birth Abroad of a U.S. Citizen)
- A copy of your unexpired U.S. passport
- An original statement from your U.S. Consular Office verifying that you are a U.S. citizen

PROOF OF PERMANENT RESIDENT (GREEN CARD)
A copy of the front and back of your Permanent Resident Card

2. PROOF OF IDENTIFICATION

- Your picture on your current State driver's license or State ID card
- A U.S. Military ID card
- A Federal, State or Local government ID card with your picture or identifying information such as name, date of birth, sex, height, color of eyes, and address

3. INCOME VERIFICATION

Please provide one of the following:

IF YOU ARE EMPLOYED
- Last 2 pay stubs or
- Income Tax Return

IF YOU ARE UNEMPLOYED (or if you work but don't file an Income Tax Return)
- Written statement from source and/or
- Written summary of your income for the past 3 months

4. COPY OF YOUR SOCIAL SECURITY CARD

QUESTIONS? Please call the Marketing Department at Mission Regional Medical Center at (956) 323-1150.

Mission Regional Medical Center

FREE SCREENING MAMMOGRAPHY APPLICATION

Application for assistance is based on need for screening mammography services and the inability to pay for such service through insurance or self pay. **FUNDS ARE AVAILABLE FOR SCREENING MAMMOGRAMS ONLY.** Application for assistance will be individually evaluated after the completion of this form. ALL QUESTIONS MUST BE ANSWERED.

Full Name _____ Date Of Birth (dd/mm/yy) _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Email _____

Spouse Name _____ If Single, check box ☐

Other Dependents 1) _____ Relationship: _____

Other Dependents 2) _____ Relationship: _____

Employer _____ If Unemployed, check box ☐

Date of last clinical breast exam _____ Physician Name _____

Health Coverage No ☐ Yes ☐ If yes, check one: Personal Policy ☐ Medicare ☐ Employer Policy ☐ Medicaid ☐

FINANCIAL INFORMATION

		MONTHLY INCOME		ESTIMATED MONTHLY EXPENSES
Employment	Patient	$ _____	Rent/Mortgage	$ _____
	Spouse	$ _____	Utilities	$ _____
	Other	$ _____	Food	$ _____
Retirement	Social Security	$ _____	Health Insurance	$ _____
	VA Pension	$ _____	Homeowners Ins	$ _____
	Employee Pension	$ _____	Car Insurance	$ _____
Other Income	Alimony	$ _____	Medical	$ _____
	Child Support	$ _____	Auto Payment	$ _____
	Investments	$ _____	Credit Card Debt	$ _____
	Public Assistance	$ _____	Other Expenses	$ _____
	Workmen's Comp	$ _____	TOTAL EXPENSES	$ _____
	Unemployment	$ _____		
	Disability	$ _____		
	Insurance	$ _____		
	Savings	$ _____		

Assets (If more space is needed, please attach separate sheet) Value

_____ $ _____

_____ $ _____

_____ $ _____

All information is considered confidential and will be used only for eligibility determination. Applications will be reviewed and evaluated to provide assistance to those with the greatest need. Funding is only provided for screening mammograms. If additional diagnostic testing is required as a result of the initial screening mammogram, Mission Regional Medical Center is in no way obligated to provide financial assistance for such service.

I agree that the above-mentioned information is correct to the best of my knowledge. I further agree that if my request is approved, I will comply with the request of Mission Regional Medical Center to supply a copy of my mammography results and other medical documentation pertaining to this service for statistical and research purposes.

_____ _____

DATE **APPLICANT SIGNATURE**

ALL 6 PAGES OF THIS APPLICATION MUST BE RETURNED BY MAIL OR IN PERSON TO:

Mission Regional Medical Center
Marketing Department
910 S. Bryan Road
Suite 301
Mission, TX 78572

For more information about this application, please call the Mission Regional Medical Center Marketing Department at **(956) 323-1150** (Office Hours: Monday - Friday, 8 am - 5 pm).

APPLICATION DEADLINE: All applications must be received on or before **July 31, 2016**.

Recipients of the free digital screening mammogram will be notified over the phone or via mail.

The digital screening mammogram must be performed at The Breast Care Center at Mission Regional Medical Center **before August 31, 2016**. Patient is responsible to call The Breast Care Center to schedule an appointment.

Mission Regional Medical Center

PATIENT AND FAMILY HISTORY

Applicant Name _____

Have you had a clinical breast exam in the last year? ☐ Yes ☐ No

If yes, when? _____ Results: ☐ Normal ☐ Suspicious ☐ Other

Please define OTHER _____

Have you received a screening mammogram from The Breast Care Center at Mission Regional Medical Center in the past? ☐ Yes ☐ No

Check if you have any of the following symptoms: ☐ Breast Lump ☐ Discharge from Nipple ☐ Pain ☐ Other

Please define OTHER _____

Have you ever had a mammogram? ☐ Yes ☐ No

If YES, when was your last mammogram? _____

Do you have a history of cancer? ☐ Yes ☐ No

If YES, what type and when? _____

Do you have a family history of cancer? ☐ Yes ☐ No

If YES, who and what type? _____

HIPPA COMPLAINT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

TO Mission Regional Medical Center
900 South Bryan Road
Mission, TX 78572

RE _____
Patient Name

_____
Street Address

_____
City, State, Zip Code

_____
Telephone Number

_____ _____
Date of Birth (mm/dd/yy) Social Security Number

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with documenting my medical care and treatment. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

All pertinent documentation and medical records including: history and physical, discharge summary, operative reports, consultation reports, lab results, progress notes, pathology reports, pharmacy/prescription records and any other pertinent documentation.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), alcohol and drug abuse, psychiatric care or other sensitive information. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the purpose of review, determination and consultation of program eligibility with Mission Regional Medical Center and should be sent to:

Mission Regional Medical Center
910 S. Bryan Road, Suite 301
Mission, TX 78572

Phone Number: (956) 323-1150
Fax Number: (956) 323-1162

Further, I understand:

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. I understand that this authorization is voluntary but is also a condition of eligibility for Mission Regional Medical Center free screening mammography program and that without a signed authorization for the release of patient information, I will not be eligible for assistance.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until one year from date of execution at which time this authorization expires.

Patient Signature _____ Date _____

Printed Name of Patient _____