ROBERT L. BARD, M.D., P.C.
121 EAST 60TH STREET STE 6A
NEW YORK, NY 10022

TEL (212) 355-7017 **WWW.CANCERSCAN.COM** **FAX (212) 752-6192**
RBARD@CANCERSCAN.COM

MEDICARE BENEFICIARY NOTICE

Patient's Name:_____ Medicare#(HICN):_____

ADVANCE BENEFICIARY NOTICE (ABN) NOTE: You need to make a choice about receiving these health care items or services. We expect that Medicare will not pay for the item(s) or service(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:**

Items or Services:_____

Rendered by:_____

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, 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 items or services will cost you (**Estimated Cost: $**_____)

Option 1. YES. I want to receive these items or services. I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services 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 items or services. I will not receive these items or services. 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.

_____

Signature (patient or person acting on patient's behalf)

_____

Date

Power Doppler Information Sheet

Robert L. Bard, MD
121 E. 60th Street
New York, NY 10022
(212) 355-7017

Patient Name:_____
Today's Date:_____
Referring Physician:_____
Date of Birth:_____

3-D "POWER DOPPLER SONOGRAPHY" OF THE PROSTATE

YOUR EXAM WILL BE 5 MINUTES LONG LOWER PANTS/SHORTS 9 INCHES
A LUBRICATED RECTAL PROBE ONE-HALF INCH THICK IS INSERTED
PICTURES ARE STORED IN THE COMPUTER AND THE PROBE IS REMOVED
THERE IS NO RADIATION OR NEEDLES
THE DOCTOR WILL REVIEW YOUR IMAGES ON A COMPUTER WORK STATION
A WRITTEN REPORT WILL BE FORWARDED TO YOU WITHIN 72 HOURS

DIGITAL RECTAL EXAM FINDING _____
DATE OF BIOPSY _____
GLEASON SCORE _____
SITE OF TUMOR APEX BASE MIDGLAND ANTERIOR
LOCATION OF TUMOR RIGHT LEFT BOTH SIDES
TREATMENT _____

DR BARD IS A RADIOLOGIST SPECIALIZING IN PROSTATE SONOGRAPHY
AND USES THE ONLY GE MEDICAL POWER DOPPLER 3 D UNIT IN AMERICA
DESIGNED SPECIFICALLY FOR EXAMINING THE PROSTATE
2/3 OF MEN OVER 50 HAVE LOW GRADE CANCER CELLS IN THEIR PROSTATE
ONLY 5% WILL DEVELOP CLINICAL OR AGGRESSIVE PROSTATE CANCER
THE EXAM TELLS IF THE CANCER IS AGGRESSIVE OR NOT AND CORRELATES
WELL WITH GLEASON SCORES AND PROGNOSIS
THE POWER DOPPLER EXAM HAS VERY HIGH GLEASON CORRELATION
HIGH VASCULARITY TUMORS METASTASIZE
TUMOR SPREAD OUTSIDE THE CAPSULE MAY BE EVALUATED
FTP MRI IS DESIGNED TO SHOW TUMOR OUTSIDE THE PROSTATE
NON INVASIVE THERAPEUTIC OPTIONS WILL BE DISCUSSED AFTER THE EXAMS

PSA and PSA_variants have 0% (zero percent) specificity
This means there is no number below which you cannot have cancer
Some high grade cancers have NO measurable PSA findings

Breast Imaging Information Sheet
(Mammography/Sonography)

Robert L. Bard, MD
121 E. 60th Street 6A
New York, NY 10022
(212) 355-7017

Patient Name: _____
Today's Date: _____
Referring Physician: _____
Date of Birth: _____

IF YOU ARE PREGNANT OR TRYING TO BECOME PREGNANT, PLEASE NOTIFY THE TECHNOLOGIST PRIOR TO EXAMINATION

Have you had a Mammogram or Breast Sonogram in this facility? YES_____ NO _____
If yes when?_____ Was it Breast Sonogram/Mammogram (please circle)
Have you had a Mammogram or Breast Sonogram at another facility? YES_____ NO _____
If yes when?_____ Was it Breast Sonogram/Mammogram (please circle)
Would you be able to obtain Originals/Copies of your Mammogram: YES_____ NO_____
Date of last physical manual examination of breasts by primary care physician _____
NOTE: **CBE** (Clinical Breast Exam) may show important finding that may alter your treatment.

History (Breast)

Have you had breast surgery (implants/reduction included)? YES ____ NO _____ When? _____
Have you been diagnosed with breast carcinoma? YES ____ NO ____ When?_____
If yes, what kind of breast carcinoma? (DCIS, LCIS, Invasive, etc.) _____
Have you ever received Radiation Therapy/Chemotherapy? YES ____ NO ____ When? ____

Breast Complaints (Current)

Discharge Yes ☐ No ☐ Right ☐ Left ☐ Color _____
Lump that you feel now Yes ☐ No ☐ Right ☐ Left ☐
Pain/Discomfort Yes ☐ No ☐ Right ☐ Left ☐
Other Problems (please explain: _____

Family History of Breast Carcinoma

Mother Yes ☐ No ☐ Grandmother Yes ☐ No ☐
Sister Yes ☐ No ☐ Other: _____
If yes, age found _____

Medications *(Include current and past)*

Hormone Therapy Yes ☐ No ☐ What kind/how long?_____
Birth Control Yes ☐ No ☐ How long? _____

Time out: all imaging tests have the possibility of false positive findings
This may result in other tests or biopsies being performed
Time out discussed:

_____
Patient's signature

Mammogram/Sonogram Report Taken _____

(Patient's Signature)

Breast Imaging Information Sheet
(Sonography)

Robert L. Bard, MD
121 E. 60th Street 6A
New York, NY 10022
(212) 355-7017

Patient Name: _____
Today's Date: _____
Referring Physician: _____
Date of Birth: _____

IF YOU ARE PREGNANT OR TRYING TO BECOME PREGNANT, PLEASE NOTIFY THE TECHNOLOGIST PRIOR TO EXAMINATION

History (Breast)

Have you had breast surgery (implants/reduction included)? YES ____ NO _____ When? _____

Have you been diagnosed with breast carcinoma? YES ____ NO ____ When?_____

If yes, what kind of breast carcinoma? (DCIS, LCIS, Invasive, etc.) _____

Have you ever received Radiation Therapy/Chemotherapy? YES ____ NO ____ When? ____

Breast Complaints (Current)

Discharge Yes ☐ No ☐ Right ☐ Left ☐ Color _____
Lump that you feel now Yes ☐ No ☐ Right ☐ Left ☐
Pain/Discomfort Yes ☐ No ☐ Right ☐ Left ☐
Other Problems (please explain: _____

Are you bringing any previous reports or films? _____

If yes, please give your previous reports or films to the receptionist.

Time out: all imaging tests have the possibility of false positive findings
This may result in other tests or biopsies being performed
Time out discussed:

_____
Patient's signature

Sonogram Report Taken _____

(Patient's Signature)