Free Breast Screening Application

Please complete and submit to: BRAS, Linda Bamber - linda@breastresearchawareness.com 417-770-0451 office 913-432-8392 fax 9337 W. 75th St. Overland Park, KS 66204

Referred by:

Date:

Name:

Birth Date:

Ethnicity:

Address:

City:

State:

Zip:

County:

Phone:

Email:

Name, address and phone number of your doctor:

Marriage status (circle one): Married Single Divorced

SEX: (circle one) Male Female

Have you noticed any new changes in your breast recently, which are not related to monthly discomfort?

In which breast? (circle one) Left Right

Which of the following apply: (circle all that apply)
Lump
Persistent Nipple Discharge
Redness
Rash
Dimpling
Unusual Pain
Change in Shape
Bulging
Inverted Nipple

How long ago was your last breast screening? (years)

Do you have fibrocystle changes in your breast (any new lumps or changes in the way your breasts feel)?

Have you ever had breast cancer? If so, at what age? Are you currently receiving treatment?

Have you ever had a Biopsy? If so, at what age?

Is there a history of breast cancer in your family? If so, what is your relation?

Whose side of the family had this history of breast cancer?

At what age? (if known)

Do you have health insurance, MEDICAID or Medicare
that will cover the cost of a mammogram?

What is your family's income as reported on your most recent tax return? (Required)

Do you collect unemployment? If so, what is your monthly income?

Do you collect disability? If so, what is your monthly income?

How many people does this support?

How did you hear about United Breast Cancer Foundation's grant with BRAS (please be specific)?

Would you agree to share your experience with UBCF?

Please include any comments, questions or needs you may have that we have not addressed on the reverse side.

Please Sign and Date:

Name: Date:

United Breast Cancer Foundation
PO Box 2421
Huntington, NY 11743
Ph: 1.877.822.4287 www.ubcf.info

UBCF has requested either a written or video testimony from women who receive financial support for thermography. We would like you to share your experience with us. Please e-mail either form of testimony to linda@breastresearchawareness.com or mail to 9337 W. 75th Street Overland Park, KS 66204.

I, _____, give permission for BRAS and/or UBCF to use my written or video testimony for future marketing purposes.

Date _____

Client Signature _____

Testimony:

Filed with UBCF _____
Date _____

United Breast Cancer Foundation
PO Box 2421
Huntington, NY 11743
Ph: 1.877.822.4287 www.ubcf.info

UNITED BREAST CANCER FOUNDATION
ASSUMPTION OF RISK AND GENERAL RELEASE FORM
Exhibit A

THIS IS A RELEASE OF LEGAL RIGHTS – READ AND UNDERSTAND BEFORE SIGNING

I am going to receive _____ [insert type of procedure] (referred to as "Procedure") from **Breast Research Awareness and Support (BRAS)** (the "Facility"). **United Breast Cancer Foundation** ("UBCF"), a New York not-for-profit corporation is providing the Facility with a monetary grant to enable the Facility to provide me with the Procedure without any cost to me. I have voluntarily chosen to obtain the Procedure from the Facility, which is being funded by UBCF. This agreement confirms my understanding of the following:

1.0 I recognize that by undergoing the Procedure at the Facility, I may be subjected to potential risks, illnesses, injuries and even death. I have made my own investigation of these risks, understand these risks and assume them knowingly and willingly. Although UBCF is providing funding for my Procedure, I understand and acknowledge that it is not responsible for any actions or omissions of the Facility, its employees, staff, or agents, nor is it responsible for any illnesses, injuries or death that may arise as a result of my undergoing the Procedure that I am undergoing at the Facility.

2.0 Knowing the risks described above, I agree, on behalf of me, my family, heirs and personal representative(s), to assume all the risks and responsibilities surrounding my obtaining this Procedure at the Facility. To the maximum extent permitted by law, I release, hold harmless and agree to indemnify UBCF, and its officers, directors, staff, representatives, employees and agents, from and against any present or future claim, loss or liability for injury to person or property which I may suffer, or for which I may be liable to any other person, related to my obtaining this Procedure from the Facility, resulting from any cause, including but not limited to ordinary or gross negligence.

3.0 In consideration of receiving the Procedure to be paid for through a monetary grant from UBCF to the Facility, I agree to provide to UBCF a testimonial of my experience obtaining the Procedure and dealing with UBCF. I acknowledge that UBCF will provide me with a testimonial form on or before the date I undergo the Procedure. I will complete the testimonial form and return it to UBCF within 5 days from the date of the Procedure.

4.0 I certify that I am age 18 or older. I have carefully read and freely signed this Assumption of Risk and General Release Form. I understand and agree that no oral or written representations can or will alter the contents of this document. I agree that the laws of the State of New York without regard to its conflicts of laws principles will govern this Agreement, which shall be the forum for any lawsuits filed under or incident to this agreement.

Signed: _____ Date: _____
Name (print): _____
Address:

If the person signing this agreement is under age 18, all parents and/or legal guardians must sign below:

I, the undersigned parent and/or legal guardian of the person listed above (the "Patient"), do hereby consent to his or her obtaining this Procedure from the Facility through funding provided to the Facility by UBCF. I, as the parent of the Patient and on behalf of the Patient, release, hold harmless and agree to indemnify UBCF, and its officers, directors, staff, representatives, employees and agents, from and against any present or future claim, loss or liability for injury to person or property which I or the Patient may suffer, related to the Patient's obtaining the Procedure from the Facility resulting from any cause, including but not limited to ordinary or gross negligence.

Signed:_____ Date:_____
Name (print):_____
Address:

Signed:_____ Date:_____
Name (print):_____
Address: