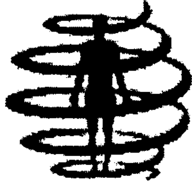


COASTAL IMAGING

CT History and Questionnaire

Date: __________ Name: ____

Date of Birth: ________________________ Age ____________

What Type of CT are you having today? What symptoms are you having and for how long? __________

____

____

List surgeries and dates:

____

____

____

Have you ever had a reaction the contrast medium used for CT? .... ____Yes _____ No

If yes, describe the reaction:

____

Please answer the following questions:

Are you allergic to any food or medication? ____Yes ____No

If Yes: what kind?

____

____

Are you diabetic? _____ Yes _____ No Do you currently take Glucophage, Metformin or any type of Metformin product? ____Yes ____No (If yes, we request you stop taking it for the next 48 hours, then resume as normal)

Are you or could you be pregnant? _____ Yes _____ No Date of last menstrual cycle: _____________

Do you have a history of cancer? _____ Yes _____ No If yes: what kind? ______________________

____

Did you receive treatments? Chemo ____Yes ____No When? ______________________________

Radiation ____Yes ____No When? ____

Do you have any of the following conditions?

Bronchial Asthma _____ Yes _____ No   High Blood Pressure _____ Yes _____ No

Kidney Disease _____ Yes _____ No   If so, are you on dialysis? _____ Yes _____ No

Sickle Cell Disease _____ Yes _____ No   Multiple Myeloma _____ Yes _____ No

Please list any other health conditions you may have: ______________________________

____

I attest that the above information is correct to the best of my knowledge. I have read and understood the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

X______________________________   ______________________________

Patient or Guardian Signature   Witness

****** The section below is filled out by the Radiology Staff**

Requires Labs: _____ Yes _____ No   Creat: ____________________

IV Contrast

Type ______________________

Lot Number ______________________

Expiration ______________________

Volume ______________________

Injection Rate ______________________

Injection Site ______________________

Scan Delay ______________________

Oral Contrast

Lot Number ______________________

Expiration ______________________

Volume ______________________

COASTAL IMAGING

MRI/CT CONSENT FORM

On certain studies, a contrast agent (oral or intravenous contrast, or both) is needed to help with the interpretation of the study. In a small percentage of cases, complications (side effects) can occur from any contrast study. Reactions include headaches, nausea, vomiting, swelling, sneezing, hives, dizziness, weakness, fever or seizures. The possibility of a more serious reactions including life threatening or death is extremely rare, but should always be considered.

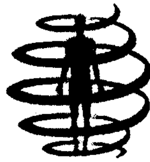
If you wish to refuse the contrast agent simply, inform the technologist, however without the contrast agent your images may not be as detailed or helpful to the radiologist and your physician.

*****Please inform the technologist if you have previously had a reaction to IV contrast or have a history of kidney disorder and or liver disorder.******

If you have any further questions regarding this procedure or its possible risks, you should discuss them with the technologists once you are called back for your study. You are asked to sign this form to verify you understand the indications for the MRI/CT and possible complications and to consent to the MRI/CT procedure and or the injection of a contrast agent.

X______________________________ ______________________________

PATIENT OR GUARDIAN SIGNATURE WITNESS

 COASTAL IMAGING

Patient Information Form

Date:____________________

[ ] Male [ ] Female

Name:____________________________ Date of Birth:___________ SSN:_____________

Mailing Address:____

City:___________________ State:_________________ Zip:_________________________

Home Phone:_______________ Work Phone:_____________ Cell phone:______________

Name of Parent/Guardian (for minors only):_____________________ Phone:________________

Address (if different from patient):____

Emergency Contact Name:_____________________ Contact Number:_________________

Patient Guarantor Employer Information

Employer's Name:___________________________ Address:____________________________
Occupation:_________________________________ Phone:_____________________

Responsible Party

Primary Insurance:_____________________ SecondaryInsurance:_____________________

Assignment and Release:

The signature below serves as authorization for the release of medical information from patient's other healthcare providers for purpose of treatment and for services rendered by Coastal Imaging for the above named patient. This signature will also serve as a release of information necessary to file insurance and assign benefits otherwise payable to policy holder, to the physician or group indicated on the claim. I authorize direct payment from my insurance company to Coastal Imaging. I understand I am financially responsible for any balance not covered by the insurance carrier.

We will file non-contracted insurance as a courtesy: however, if we have no response from your insurance company within 60 days, the charges will be transferred to your responsible party.

Signature: X_____________________________________ Date:____________________

For office use only:_____________________________ Date:_________________________

COASTAL IMAGING

Patient Financial Policy

Thank you for choosing our imaging center. We are committed to providing the best possible medical care. The following information is provided to avoid any confusion regarding payment for professional medical services.

Payment Policy

- You will receive one bill for services provided at Coastal Imaging that includes the exam performed and professional interpretation.
- Payment is due at the time services are rendered unless other arrangements have been made by either you or your insurance company.
- We accept cash, check, Visa and MasterCard.
- Patients are responsible for their deductible or charges not reimbursed by insurance.
- If the patient is a minor (18 years or younger), the parent or guardian is responsible for payment of the account, accordance with policy outlined above.
- As a courtesy, we will automatically file your insurance claims; therefore we will request a copy of your insurance card at the time of each visit.
- For services estimated to cost more that $200.00, we will accept a minimum payment of half of the expected bill. Upon request, a short-term payment arrangement can be considered.
- You will receive monthly statements. If your account is not paid within 60 days your account will be considered past due.
- Patients having health insurance will be expected to contact their insurance carrier if there is a delay in payment. Please understand that insurance is a contract between you and your carrier, therefore, you are ultimately responsible for your bill.
- If you have difficulty paying your account, please contact our billing department.
- In cases of divorce, the parent who brings the child/children in for treatment is responsible for payment: there are no exceptions.

Referrals

It is your responsibility to bring any required referrals for treatment at, or prior to, the time of your visit. If you do not have a referral, your visit will be rescheduled, or you may be financially responsible.

Acknowledgment and Authorization

I have read, understand and agree to the above policies. I understand the charges not covered by my insurance company, as well as co-payments and deductibles are my responsibility.

I authorize my insurance benefits be paid directly to Coastal Imaging.

I authorize Coastal Imaging to release any medical or other information to my insurance company when requested.

Patient Name X______________________________ Date ____________________

Patient's Signature X____________________ Parent/Guardian ____________________
(If patient is a minor)

COASTAL IMAGING

Patient Record of Disclosures

In general, HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner: (Check all that apply)

__ Work telephone __Ok to leave message with detailed information

__ Home telephone __Ok to leave message with detailed information

__ Written communication __ Ok to mail to my home address

***Please list only persons able to discuss treatment, appointments, release prescriptions and/or medical records on your behalf in your absence. Note: All persons listed must present valid ID when acting as your representative.

Please print authorized persons only:

1.______________________________ __Appts ___RX __All records

2.______________________________ __Appts __RX __All records

3.______________________________ __Appts __RX __All records

Patient's signature:X__________________ Date:________________

Acknowledgement and Receipt of HIPAA Policies and Procedures

I __________________________ hereby acknowledge that I have received and reviewed the HIPAA policies and procedures, detailing how information may be used and disclosed as permitted under federal and state law.

I understand that I am responsible for complying with the policies and procedures and that I am required to see guidance from the Privacy Officer if I have any question or concerns regarding patient confidentiality.

Patient/Guardian signatureX________________________ Date:________________

Witness:______________________________ Date:____________________