



Patient Registration Form (PLEASE PRINT)

For Office Use Only: Auto ___ WC ___ Self-Pay ___

PATIENT INFORMATION

Patient Full Name: _____ Patient's DOB: _____
Last First Middle Initial

Patient's SSN: _____ Gender: M ___ F ___ Marital Status: S ___ M ___ D ___ W ___

Street Address: _____

City/State/Zip Code: _____

Phone 1: (____) _____ Type: Home ___ Cell ___

Phone 2: (____) _____ Type: Home ___ Cell ___

Ethnicity: Hispanic or Latino ___ Non-Hispanic or Latino ___ Other or Undetermined ___

Race: Asian ___ Black or African American ___ Caucasian ___ American Indian or Alaskan Native ___ Chinese ___

Pacific Islander ___ Native Hawaiian ___ Filipino ___ Japanese ___ Multiracial ___ Other ___ Undetermined ___

Emergency Contact Name: _____

Emergency Contact Phone: (____) _____ Relationship to Patient: _____

Email Address: _____

Please indicate below what type of information that may be shared at the email address you have provided above:

All ___ Scheduling/Appointment ___ Billing/Insurance ___ Health Related Newsletter ___ Medical Records ___

Employer: _____

Occupation: _____ Work Phone: (____) _____

Employer Address: _____

City/State/Zip Code: _____

RESPONSIBLE PARTY INFORMATION

Who will be responsible for your account? Self ___ Other _____
(IF SELF, SKIP THIS SECTION)

Responsible Party Name: _____
Last First Middle Initial

Patient's Relationship to Responsible Party: _____

Responsible Party Street Address: _____

City/State/Zip Code: _____

Home Phone: (____) _____ Cell Phone: (____) _____

INSURANCE INFORMATION (Please provide Insurance Card & Photo ID to Front Desk)

Primary Insurance Company Name: _____

Insurance Address: _____

City/State/Zip Code: _____

Phone Number: (____) _____

Member ID Number: _____ Group Number/Name: _____

Name of Policy Holder: _____

Policy Holder Date of Birth: _____ Policy Holder's SSN: _____ Relationship to Patient: _____

If you have Secondary Insurance, please complete this section:

Secondary Insurance Company Name: _____

Insurance Address: _____

City/State/Zip Code: _____

Phone Number: (____) _____

Member ID Number: _____ Group Number/Name: _____

Name of Policy Holder: _____

Policy Holder Date of Birth: _____ Policy Holder's SSN: _____ Relationship to Patient: _____

ASSIGNMENT OF BENEFITS OTHER THAN MEDICARE: I hereby assign and authorize payments for services rendered to be paid directly to ProScan Imaging. I understand that my insurance carrier(s) may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization or medical necessity. I understand that I am responsible for any charges not paid in full, co-payments, deductibles and co-insurance except where my liability is limited by contract or state or federal law. A photocopy of this document shall be as valid and as effective as the original.

FOR MEDICARE PATIENTS ONLY: I certify that the information given by me in applying for payment under Title XVII of the Social Security Administration or its intermediaries or carriers is the correct information needed for Medicare claims. I hereby authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services or its agents, intermediaries or carriers any information needed to determine these benefits or the benefits payable for related services. I further understand that deductibles, coinsurance and any other charges not covered by Medicare are my responsibility.

RELEASE OF MEDICAL INFORMATION: I authorize ProScan Imaging to release the medical records concerning myself or my dependent to any physician, hospital or agency involved in the care of the patient listed on this form.

PAYMENT POLICY: Co-payments, Co-insurance and deductibles will be collected at the time services are rendered. We accept cash, checks, and credit cards. You will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance.

COMMUNICATIONS AUTHORIZATION: I hereby consent to receive auto-dialed and/or pre-recorded telephone calls from or on behalf of ProScan Imaging at the telephone numbers provided above, including my wireless number, if applicable. I understand that this consent is not a condition of receiving services from ProScan Imaging.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION AND PAYMENT POLICIES.

Signature of Patient or Responsible Party: _____ Date: _____
(if under 18 yrs of age)

Patient's Name _____ Date of Birth ____/____/____

What is a Computed Tomography (CT) scan?

The purpose of this exam is to provide your doctor with diagnostic information. The CT scanner creates images using an x-ray tube and detectors. The X-ray tube is rotated around your body to produce the images.

You will be asked to remove any metal objects or jewelry from the region being scanned. You will need to change into a hospital gown. Average scan time is 30 minutes, though it could range from 15 to 60 minutes. You will be asked to hold still during this time. You also may be asked to hold your breath for a portion of the images.

A technologist will monitor you throughout the scan. You can easily communicate with us at any time during the test. Please let us know promptly about any discomfort or distress.

While the procedure involves the use of radiation, the dose you will receive today is minimal and the lowest dose required for the test.

What are the risks?

The risks of a CT scan are similar to that of conventional X-ray. While there is a brief exposure to radiation during the CT scan, it is the smallest dose possible to gather the information needed. It is widely agreed in the medical and scientific community that the benefits gained by the information provided by CT scans outweighs any associated risks.

An abdominal CT scan is usually not recommended for pregnant women, because it may harm the unborn child. Women who are or may be pregnant should speak with their healthcare provider prior to the exam to determine if ultrasound could be used instead.

If you are breast-feeding, pregnant, or are potentially pregnant, please inform the technologist before beginning the procedure.

What Are the Radiation Risks?

CT scans and other x-rays are strictly monitored and controlled to make sure they use the least amount of radiation. CT scans do create low levels of ionizing radiation, which has the potential to cause cancer and other defects. However, the risk associated with any individual scan is small. The risk increases as additional studies are performed.

What are the alternatives?

In some cases, depending on individual factors such as the symptoms present and the condition being investigated, there may be alternatives to having a CT scan. These may include an MRI scan, which uses a magnetic field to create very detailed images; an ordinary X-ray, which are far less detailed pictures than CT or MRI; or an ultrasound scan, which uses sound waves to create images.

In the event that an intravenous contrast injection is required, the iodinated sterile solution used will be explained to me and I will be asked to sign an Addendum to this Consent.

What is Iodinated contrast?

As part of your scheduled procedure, you will receive contrast media. This will help the radiologist to see the area being studied. There are two different types of iodinated contrast media; you may receive an iodinated sterile solution or barium sulfate suspension (an oral contrast). Most patients have no problems with contrast administration. Serious contrast reactions are rare, occurring in 1-2 per 10,000 examinations. The medical personnel in charge of your exam are prepared and trained to respond to these types of reactions.

CONTINUED ON BACK

What are the risks to iodinated contrast?

Patients receiving intravenous or intra-articular iodinated sterile solution may occasionally experience headache, nausea, or localized pain around the injection site. Although iodinated contrast has been found to be a safe agent to use, there is always the risk of a reaction. These reactions can range from minor ones such as nausea, warmth at the injection site, headache, dizziness, itching, flushing, and hives to more severe reactions such as cardiac arrhythmias, shortness of breath, wheezing, convulsions, unresponsiveness, or even death. Rare complications may also include bleeding around the injection site, inflammation, and infection of the vein and possible infiltration of contrast near the site. Patients with impaired kidney function may experience further deterioration of their kidney function after the injection of iodinated contrast. A variety of medical conditions like diabetes mellitus, heart disease, and high blood pressure may impair kidney function. Patients with these or other pre-existing medical conditions that impair kidney function may be at increased risk for this complication if injected with iodinated contrast.

Patients receiving an oral barium sulfate suspension may occasionally experience nausea, vomiting, diarrhea, abdominal cramping, and constipation.

Patients receiving either type of contrast media may experience an allergic reaction. Allergic reactions can vary greatly in their degree of seriousness, from mild to severe. Mild reactions include hives, itching, and redness of the skin. Severe reactions may include trouble breathing or swallowing, or chest pain.

A doctor will be on the premises at all times during your scan. We will also monitor you throughout the procedure. You can easily communicate with us at any time during the test. Please inform your technologist of any distress or discomfort. Many patients report feelings of warmth, the sensation of needing to urinate, or a metallic taste in their mouth.

If you receive contrast media, drink extra fluids and limit your caffeine intake for the rest of the day following this procedure. You may have pain or bruising around the injection site. If you have any swelling or redness around the injection site or experience nausea, vomiting, develop hives, itching, or feel flushed, please contact ProScan immediately at the telephone number provided. If your symptoms are severe or you reach an after-hours voicemail, seek emergency medical attention immediately.

What are the alternatives to iodinated contrast?

Alternatives to using contrast media are available. These procedures may be able to provide the necessary diagnostic information. Please ask to speak with the technologist or supervising physician should you have any questions regarding an alternative imaging procedure.

By signing this you agree that you have read this form and/or I have received oral communications of all the information provided in this form. You understand the information, and have had any questions answered regarding this procedure and who will read the exam. In addition, you agree that you 1) have been explained the purpose of the procedure; 2) have been informed of how long the procedure will take; 3) understand the risks, benefits, and complications associated with the procedure; 4) have truthfully informed ProScan of my current medical condition and have complied with any requirements for having this procedure that have been communicated to me; 5) are aware of possible alternatives; and 6) have been given the right to refuse to consent to the procedure.

I have not been pressured to sign this consent and do so voluntarily. I understand that I may contact ProScan at the address and phone number provided if I have any further questions about this form or the procedure. I am at least 18 years of age, of sound mind and not under the influence of alcohol or hallucinogenic drugs. I have no reservations and give my consent to start and complete the exam(s) by my signature and date here.

Patient's and/or Appropriate Agent's Signature _____

Printed Name: _____

Date: _____



HIPAA Acknowledgment & Office Policies

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE AND AGREE TO THE FOLLOWING POLICIES:

RESPONSIBILITY FOR VALUABLES. ProScan does not assume responsibility for securing any and all valuables and personal items belonging to patients or visitors. You are responsible for securing all valuables or personal items prior to your imaging exam.

**I have read and understand the above statements and acknowledge that ProScan and its employees are not liable for the loss or theft of my valuables or personal items.*

CHILDREN IN THE WAITING ROOM. ProScan is not responsible for providing supervision of any child during your imaging exam. You are welcome to bring your child or children if there is another adult accompanying you to supervise your child or children while your imaging exam is being done.

**I have read and understand the above statements and acknowledge that ProScan and its employees will not be responsible for providing childcare for my child or children during my imaging exam.*

CANCELLATION POLICY. If you will not be able to appear for your scheduled appointment, you must notify ProScan 24 hours prior to your appointment time. If you miss or cancel your appointment without giving the appropriate 24-hour notice, ProScan may charge you a \$50.00 cancellation fee.

**I have read and understand the above statements and acknowledge that if I do not provide ProScan with 24 hours prior notice that I cannot keep my scheduled appointment, I may be charged a \$50.00 cancellation fee.*

BY SIGNING THIS DOCUMENT BELOW, I HEREBY ACKNOWLEDGE THAT I HAVE BEEN OFFERED AND/OR HAVE RECEIVED A COPY OF PROSCAN IMAGING AND AFFILIATED ENTITIES NOTICE OF PRIVACY PRACTICES.

I hereby give my consent for ProScan Imaging and Affiliated Entities to release my protected health information to the following individual(s): *(PLEASE PRINT)*

_____	Relationship to Patient _____
_____	Relationship to Patient _____
_____	Relationship to Patient _____

FOR PROSCAN IMAGING USE ONLY – RECEIPT OF NOTICE OF PRIVACY PRACTICES ONLY	
Date Acknowledgment Received: _____	Initials: _____
-OR-	
Reason Acknowledgment was not obtained: _____	

_____	Date: _____
Patient or Legal Representative Signature	
_____	_____
Print Name	Relationship/Authority if Legal Representative



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Health History Questionnaire for CT Examination

Patient Name: _____ Date of Service: ___/___/___

DOB: ___/___/___ Age: _____ Sex: _____ Height: _____ Weight: _____

List all surgeries you had in your lifetime: _____

List all known allergies: _____

The following listed medical conditions could significantly alter your CT procedure and diagnosis.

Please check if you have any of these items:

- | | | |
|--|--|---|
| <input type="checkbox"/> Family history of heart disease | <input type="checkbox"/> Sedentary Lifestyle | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Valvular Heart Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Single Kidney |
| <input type="checkbox"/> Known Heart Disease | <input type="checkbox"/> High Triglycerides | <input type="checkbox"/> Kidney transplant or dialysis |
| <input type="checkbox"/> Heart attack, angina | <input type="checkbox"/> Diabetes not controlled by diet | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Currently taking Glucophage | <input type="checkbox"/> Multiple Myeloma |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Overweight | <input type="checkbox"/> Polycythemia (increase in red blood cells) |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Current Smoker: how long? _____ | <input type="checkbox"/> Asthma or history of Asthma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Former Smoker: quit when? _____ | <input type="checkbox"/> Chest Pain or pressure |
| <input type="checkbox"/> Known Vascular Disease | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> Recent Stroke |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Post Menopausal | |

Yes No Are you pregnant? Date of last period: _____

Yes No Are you breastfeeding?

Yes No Have you ever had an allergic reaction to intravenous contrast?

Yes No Have you ever been treated for cancer?

Cancer treated with: Surgery Chemotherapy Radiation Therapy

Other exams/procedures performed in relation to the area being scanned today:

	Facility where performed	Date of procedure
X-ray	_____	___/___/___
CT Scan	_____	___/___/___
MRI/MRA	_____	___/___/___
Ultrasound	_____	___/___/___
PET	_____	___/___/___
Nuclear Med Scan	_____	___/___/___

Tech Notes:

Contrast Injected? Yes No

Contrast: Optiray _____	Volume _____ ml	Delay _____	Injection site _____
Oral Contrast _____		Date ___/___/___	
Assessment completed by: _____		Date ___/___/___	
Radiologist: _____		Date ___/___/___	
Mode _____	Incrementation _____		Injection Rate _____
Infiltration or reaction – describe _____			

Health History Questionnaire for Iodinated Contrast Administration

WARNING! If you have impaired kidney function, require kidney dialysis, or have a personal history of kidney disease, please notify a staff member IMMEDIATELY.

Patient Name _____ Date of Birth ___/___/___

Examination Type _____ Examination Date ___/___/___

- Yes No Do you have any drug allergies? Please list: _____
- Yes No Are you allergic to iodine or shellfish?
- Yes No Have you ever had an allergic reaction to iodinated contrast?
- Yes No Do you have other severe allergies? If so, please list: _____
- Yes No Do you have asthma or other allergic respiratory diseases?
- Yes No Are you or could you possibly be pregnant?
- Yes No Are you breast-feeding? Breast milk should be discarded for 48 hours after injection.
- Yes No Do you have hemolytic anemia?
- Yes No Do you have sickle cell disease?
- Yes No Do you have thyroid cancer?
- Yes No Are you 70 years of age or older?
- Yes No Do you have a history of kidney disease? Kidney transplant?
- Yes No Do you have a collagen vascular disease (rheumatoid arthritis, scleroderma, myositis, osteogenesis imperfecta, etc.)?
- Yes No Do you have systemic lupus erythematosus?
- Yes No Do you have multiple myeloma?
- Yes No Do you have poorly controlled hypertension (greater than 180/110 mmHg)?
- Yes No Do you have hyperuricemia?
- Yes No Do you have cardiomyopathy or congestive heart failure?
- Yes No Do you have diabetes?
- Yes No Do you have cirrhosis of the liver?
- Yes No Are you currently taking any medication containing metformin? These include Metformin (generic), Avandamet, Glucophage, Glucophage XR, Glucovance, and Metaglip, Glumetza, Fortamet, Riomet, ACTOPLUS Met, Janumet.
- Yes No Are you currently taking any non-steroidal anti-inflammatory drugs (NSAIDs)? These include Diclofenac (Voltaren, Voltaren XR), Diclofenac/misoprostol (Arthrotec), more than 800 mg per day Ibuprofen (Motrin, Advil, Nuprin), Indomethacin (Indocin, Indocin SR), Nabumetone (Relafen), Naproxen (Naprosyn, Aleve, Anaprox, Anaprox DS, Naprelan), and Oxaprozin (Daypro).
- Yes No Are you currently taking a diuretic called Furosemide (Lasix) or Spironolactone (Aldactone)?
- Yes No Are you currently taking any of the following antibiotics: Amikacin (Amikin), Amphotericin B (Amphocin or Fungizone), Gentamicin (Garamycin), Kanamycin (Kantrex), Netilmicin (Netromycin), Streptomycin, Tobramycin (Nebcin), or Vancomycin (Vancocin)?
- Yes No Have you had an MRI or CT in the last 72 hours that involved contrast injection?

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form, and have had the opportunity to ask questions regarding the information on this form and the procedure I am about to undergo.

Signature of Person Completing Form: _____ Date ___/___/___

Signature of CT Technologist: _____ Date ___/___/___

Post-Procedure Instructions for Iodinated Contrast

- Following completion of your CT scan today, you may continue with your normal daily activities.
- Please make sure that you remain well hydrated for the next 12 hours. Drink an additional 1-2 glasses of water.
- If you are breastfeeding, you should discard your breast milk for the next 48 hours as iodinated contrast media will be present in the milk for that time period.
- Although it is rare to experience any delayed allergic reactions, please call the center to speak with the supervising physician if you develop a rash or hives. In the event that you have a severe reaction, such as shortness of breath or facial swelling, please call 911.
- If you are taking an oral medication to treat diabetes containing metformin (ACTOPLUS Met, Avandamet, Glucophage, Glucophage XR, Glucovance, Glumetza, Foramet, Metaglip, Janumet, Riomet) you should discontinue the medication at the time of the exam and withhold it for 48 hours following your CT procedure. You will need to have your serum creatinine level checked at 48 hours and make sure it is normal or back to your baseline level before resuming metformin. **Please consult with your primary healthcare provider regarding discontinuing your metformin-containing medication and restarting it following your procedure.**
- If you have any further questions regarding your CT examinations, please speak with the technologist.

I read and understand the contents of this form, and had the opportunity to ask questions regarding the information on this form and the procedure I am about to undergo.

Signature of Patient or Appropriate Agent: _____ Date ____/____/____

Signature of MRI Technologist: _____ Date ____/____/____



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