PROSCAN imaging
The Most Trusted Name in Medical Imaging

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**: (_____) _____

revision date: 10/2014

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: _____
Last First Middle Initial

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: _____
Last First Middle Initial

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)

revision date: 10/2014

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Informed Consent for Computed Tomography (CT) WITHOUT CONTRAST

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.

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: _____

revision date: 10/2014

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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:

__Family history of heart disease
__Valvular Heart Disease
__Known Heart Disease
__Heart attack, angina
__Irregular Heart Beat
__Heart Surgery
__Congestive Heart Failure
__High Blood Pressure
__Known Vascular Disease
__Seizure disorder
__Hives
__Sedentary Lifestyle
__High Cholesterol
__High Triglycerides
__Diabetes not controlled by diet
__Currently taking Glucophage
__Overweight
__Current Smoker: how long? _____
__Former Smoker: quit when? _____
__Back Pain
__Brain Tumor
__Post Menopausal
__Kidney disease
__Single Kidney
__Kidney transplant or dialysis
__Sickle Cell Disease
__Multiple Myeloma
__Polycythemia (increase in red blood cells)
__Asthma or history of Asthma
__Chest Pain or pressure
__Shortness of Breath
__Recent Stroke

☐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 _____

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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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