3100 Matlock Suite 105, Arlington, TX 76015
Phone 817-543-2412

PATIENT INFORMATION:_____ JACKET#:_____ PATIENT#_____

Last Name: _____ First Name**:**_____ Male____ Female____

Home Address: _____City: _____ State:_____ Zip: _____

Date of Birth:____/____/____ Age: ____ Social Security: _____-_____-_____ Marital Status:_____

Home Phone#: _____ Cell#: _____ E-mail: _____

Ethnicity:_____ Race:_____Preferred Language:_____Nationality:_____

Height:_____ Weight:_____ Driver's License #:_____ State Issued:_____

Do you smoke: _____ How many packs per day:_____ How long:_____ Ever smoked:_____

Emergency Contact Name: _____ Phone#_____

REFERRED BY:_____

Doctor:_____Phone #_____

Primary Care Physician: _____ Phone #_____

INSURANCE INFORMATION_____ (please complete all information)_____

Insurance Co Name: _____ Phone #:_____

Claims filing Address:_____ City: _____ State:_____ Zip:_____

Subscribers/Guarantor Name: _____ Date of Birth: ____/___/____

Subscribers/Guarantor Address:_____ City: _____ State:_____ Zip: _____

Social Security: _____-_____-_____ Patients relationship to Subscriber: _____

Employer: _____ Employer Address:_____

Home Phone:_____Cell Phone: _____Driver's License #:_____State:_____

InsuranceIdentification#:_____ Group#:_____

SECONDARY INFORMATION_____

Insurance Co Name: _____ Phone#:_____

Claims filing Address:_____ City: _____ State:_____ Zip:_____

Subscribers Name: _____ Date of Birth: ____/___/____

Social Security: _____-_____-_____ Patients relationship to Subscriber: _____

Employer: _____ Employer Address:_____

Insurance Identification#:_____ Group#:_____

WORKERS COMP/ATTORNEY INFORMATION_____

Was this a result of a car accident?yes___ no___was this a result of a work related injury? yes __ no___

Workers Comp /Attorneys: Name _____Phone#: _____

Mailing Address:_____ City:_____ State:_____

WC Claim #_____

CENTRAL IMAGING OF ARLINGTON

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Pt. Name:_____

DOB:_____

Weight _____lbs.

CONTRAST MEDIA HISTORY & ASSESSMENT

Examination:
Abdominal CT ☐ Neuro CT ☐ IVP ☐ Other ☐

You have been scheduled for a diagnostic x-ray test which requires contrast material (x-ray dye) to be administered through an intravenous (IV) line in your arm. Contrast material helps to enhance certain portions of the body on the x-ray image.

If you are having an abdominal CT scan, in order to get the best images possible, you may be required to drink a large amount of liquid contrast material.

To be completed by Patient or Guardian:

YES	NO	
☐	☐	Are you allergic to contrast material/x-ray dye?
☐	☐	Have you had a previous x-ray exam using IV contrast material (IVP, CT, angiography, etc.)?
☐	☐	Have you ever had asthma?
		Are you allergic to:
☐	☐	iodine?
☐	☐	foods?
☐	☐	pollen?
☐	☐	drugs?
☐	☐	Reglan?
☐	☐	Other?
☐	☐	Do you have a history of kidney disease?
☐	☐	Do you have only one kidney or a renal (kidney) transplant?
☐	☐	Do you have a history of diabetes?
☐	☐	Have you taken the drug GLUCOPHAGE (metformin hydrochloride) in the last 48 hours?
☐	☐	Do you have a history of heart disease?
☐	☐	Do you have sickle-cell anemia?
☐	☐	Do you have pheochromocytoma or myeloma?
☐	☐	Are you pregnant or do you suspect that you might be pregnant?
☐	☐	Have you had any recent blood work at the medical center?
☐	☐	How long has it been since you ate or drank?

POST-CONTRAST INSTRUCTIONS:

Please drink 8 glasses of water today. (avoid beverages such as coffee, tea or soda pop which contain caffeine and avoid alcoholic beverages.)

If you IV site is sore, reddened or swollen, apply a warm, wet washcloth to the area for 15-20 minutes four times a day and elevate your arm on a pillow. **Call your doctor if this persists beyond 48 hours.**

I acknowledge that I have read this document in its entirety, that I fully understand it, that all my questions referable to it have been answered to my satisfaction, that all the blank spaces have been completed and that I agree and consent to the use of this diagnostic material.

Signed _____ **Date:** _____
(Patient or Guardian)

To be completed by Technologist or Nurse:

Creatinine _____ mg/dl Date:
Patient ID #:
Date and time of injection _____ Injection Site _____
Type and amount of contrast injected _____
Signature of person injecting _____
Comments _____

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CAT SCAN QUESTIONNAIRE

Patient Name: _____DOB: _____

Referring Physician: _____

What kind of trouble are you having? _____

Are you having any numbness or tingling? ☐ Yes ☐ No

If yes, Where? _____

Are you having pain in your arms or legs? ☐ Yes ☐ No

☐ Right Leg ☐ Left Leg ☐ Right Arm ☐ Left Arm

Are you having blurred or double vision? ☐ Yes ☐ No

Are you having headaches? ☐ Yes ☐ No

Are you having any nausea or vomiting? ☐ Yes ☐ No

How long have you had these symptoms? _____

Have you had any of the following tests? (Relating only to today's visit) If yes, where and when?

☐ CAT Scan _____

☐ MRI _____

☐ X-Ray _____

Have you had previous surgery? ☐ Yes ☐ No If yes, what type and when?

_____

Do you have any of the following health problems?

☐ Asthma ☐ Diabetes Mellitus ☐ Claustrophobia ☐ Other_____

Are you allergic to any medications or iodine? ☐ Yes ☐ No If yes, what kind?

_____

****

I hereby grant permission to Central Imaging of Arlington and Reading Radiologists' as they may designate, to perform and administer all treatments, which in their judgment may be considered necessary or advisable for the patients' well being. Further, I agree that Central Imaging of Arlington and Reading Radiologists' may give out written or verbal information concerning my medical records, to any insurance carrier or agent that is authorized to have access to, and to make copies of my medical records.

Patient Signature _____ **Date:** _____

Witness Signature _____ **Date:** _____

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MEDICAL BACKGROUND

Briefly explain any problems you are experiencing: _____

_____

_____

Please indicate if you have ever experienced any major medical or surgical history: _____

_____

_____

Have you had any prior X-Rays pertaining to this condition? _____

If so, please indicate when & where: _____

_____

Date of Injury: _____

Please check type of accident: ☐ Motor Vehicle ☐ Work Related ☐ Other

Briefly explain: _____

_____

Please indicate if you have or are experiencing:

☐ Reaction to X-Ray Dye
☐ Cardiac Dysfunction
☐ Generalized Severe Debilitation (weakness)
☐ Asthma or Allergy
☐ Sickle Cell Disease

Signature: _____ **Date:** _____

*** For female patients only***

Date of last menstrual period: _____

Do you use any contraceptive? ☐ Yes ☐ No If so, what type? _____

Is there any possibility that you could be pregnant? ☐ Yes ☐ No

Tubal ligation? ☐ Yes ☐ No Date performed _____

Hysterectomy: Partial or Complete Date performed: _____

Signature: _____ **Date:** _____

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Radiology Films

I acknowledge that if previous films are not immediately available for comparison, this may delay interpretation of the study to be performed today, and if previous films cannot be located, interpretation of today's service may not be as reliable as would be anticipated had comparison films been available.

Additional Fees

To obtain a **personal** copy of images, **CD is $5.00** and **films are $8.00 per sheet.** To request your study be read on STAT basis (as soon as possible) this is not medically necessary or ordered by your doctor then it is a $30.00 fee.

All patients need to give a 24-hour notice to pick up CD or films.

Central Imaging of Arlington does not honor DNR.

Patient Signature _____ **Date:** _____

Witness Signature _____ **Date:** _____

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PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of the provision of health services, Central Imaging of Arlington creates and maintains health records and other information describing, among other things, my clinical history, symptoms, examination, results, diagnoses, treatment, radiology films, and any plans for further care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that Central Imaging of Arlington reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting premium rating, conducting or arranging for medial review, legal services, and auditing functions, etc.) and that Central Imaging of Arlington is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment of healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my protected health information, which is used or disclosed for the purposes of treatment or payment of healthcare operations, be restricted. I also understand that Central Imaging of Arlington and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my protected health information which have been previously agreed upon.

_____ _____

Signature of Patient Date Signed

Patient's Name Printed Social Security Number Date of Birth

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AUTHORIZATION FORM FOR RELEASE/RECEIPT OF PROTECTED HEALTH INFORMATION

I, _____, D.O.B., _____ SS# _____
(PRINT NAME)
hereby authorize Central Imaging of Arlington ("practice") to use, receive, and/or disclose the protected health information for billing and other purposes.

The person and/or facility to whom the information will be released to or received from: _____

_____

Central Imaging of Arlington is hereby authorized to receive and/or disclose to the aforementioned person and/or facility and the aforementioned person and/or facility is hereby authorized to use or disclose the information. This authorization shall be in force and effective for **one year from the date signed below**.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. Phyllis Frostenson at Central Imaging of Arlington at P.O. Box 150268, Arlington, Texas 76015. I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its action. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

Central Imaging of Arlington will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Print Name of Patient or Personal Representative Description of Personal Representative's Authority