

Carlsbad Imaging Center
(760) 730-3536

PATIENT PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle: _____
Street Address: _____ Apt# _____
City: _____ State: _____ Zip Code: _____ Driver License (State & #) _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Date of Birth: _____ Sex: Female Male Social Security Number: _____
Marital Status: Single Married Divorced Widowed
Name of Employer or School: _____
Is your condition a result of work comp? Yes No If yes, please give date of injury _____

PATIENT'S PRIMARY INSURANCE INFORMATION

Primary insurance company's name _____
Name of Insured: _____ Date of Birth: _____
Relationship to Insured Self Spouse Child other _____

PATIENT'S SECONDARY INSURANCE INFORMATION

Secondary insurance company's name _____
Insurance Address: _____
Name of Insured: _____ Date of Birth: _____
Relationship to Insured Self Spouse Child other _____

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS AND FILMS

I, _____, hereby authorize, the above named facility, to release the medical records, diagnostic report and /or film of:

Patient's Name: _____
Date of Birth: _____ Medical Record# _____
Specific exam/exams: _____ Date of service: _____
To: Name: _____ Phone: _____

I understand that this authorization shall become effective immediately and shall remain in effect until I revoke it, in writing. I also agree to pay any fee associated with copying of second set of films.
Applicable Fees: \$15.00 per film

Print Name: _____
Signature: _____ Date: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Street Address: _____ Apt# _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

AUTHORIZATION

† **ASSIGNMENT OF BENEFITS:** I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due me under my insurance plan. I also hereby authorize this provider to use and disclose any of my personal medical information for treatment/diagnosis and payment (including to my insurance company). I agree to pay the balance of charges not paid under my plan. I am aware that if my account is not paid in full within 90 days from the date of the service, a 30% additional fee will be added to the balance and it will be sent directly to a collection agency and reported to a national credit bureau. The returned checks will also be charged a \$25.00 fee. Should the account be referred to an attorney for collection, the undersigned shall pay attorney's fees and other collection expenses. **IF I AM UNINSURED, I am fully responsible for all charges.**

Signature: _____ Date: _____

† **CONSENT FOR MEDICAL TREATMENT/DIAGNOSIS:** I authorize the imaging Center to furnish the necessary medical treatment , or procedures, including diagnostic x-ray, local anesthesia, drugs, and supplies as may be ordered by the attending physician(s), his assistants or designees. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment or diagnostic procedures conducted in the Imaging Center.

Signature: _____ Date: _____

† **LIFETIME MEDICARE B SIGNATURE AUTHORIZATION:** I authorize any holder of medical or other information about me to release to the Social Security Administration and center for Medicare & Medicaid Services or it's intermediaries or carriers, or to the billing agent of the Imaging Center any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits be made to the holder of this assignment on my behalf. I understand that I am responsible for any deductible and coinsurance.

Signature: _____ Date: _____

IF PATIENT IS UNDER 18: I hereby give my permission for _____ to be treated at the Imaging Center.

In accordance with city, state, and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**), **Carlsbad Imaging Center** will protect patient records and other information that may reveal a patient's identity when using or disclosing such information for purposes of treatment, payment, or health care operations. I am aware that I can request to review the policy of **Carlsbad Imaging Center** for patient's privacy.

Signature: _____ Date: _____

C.T. QUESTIONNAIRE

Carlsbad Imaging Center
3144 El Camino Real Suite 100
Carlsbad, Ca 92008
Fax# (760) 720-4833
(760) 730-3536

Date: _____ Name: _____ Age: _____

1. In one sentence, please describe what made you go to your doctor:

2. Please list any symptoms you are currently having which you feel are related to your problem (i.e. pain, nausea, weight loss, etc.):

3. Have you had any other test related to this problem (i.e., lab, x-ray, barium enema, UGI, ultrasound, M.R.I., or previous C.T.? Yes No. If yes, what test? and which facility?

4. Please list any surgeries you have had:

5. Please list any medication you are taking and what it is for:

6. Have you ever been told you had cancer? Yes No If yes, what body part was affected?

7. Is there any chance you could be pregnant? Yes No
8. Are you currently breastfeeding? Yes No

TECHNOLOGIST NOTES:

INJECTION INFORMATION

I.V. Site _____

Type: Butterfly Angiocath CONTRAST: _____

Amount: _____ Bolus Infusion Power Injector Infiltration

Patients Response: _____

Injected By: _____

C.T. INFORMED CONSENT SHEET

**Carlsbad Imaging Center
3144 El Camino Real Suite 100
Carlsbad, Ca 92008
Fax# (760)720-4833
(760) 730-3536**

This x-ray examination of the body is done by using a special computer which allows us to view internal organs which we are not able to visualize using standard x-ray.

Some C.T. examinations require the injection of a contrast media into your bloodstream. The use of this solution helps us to visualize certain organs inside the body which are not normally seen well and provides the radiologist with information which is necessary in evaluating your exam.

The contrast agent is given through a small needle placed into the vein. Contrast media is considered quite safe; however any injection carries a risk of harm including injury to a nerve, artery, or vein, or infection or reaction to the material being injected. Occasionally, a patient will have a mild reaction to the contrast material and develop sneezing and/ or hives. Uncommonly, more serious reactions have been known to occur, including life-threatening reactions. These serious reactions are very rare.

1. Have you ever had an "allergic"-like reaction to any contrast material which required treatment? Yes No
2. Do you have allergies or asthma? Yes No
3. Do you have any known allergies to seafood? Yes No
4. Do you have history of heart disease? Yes No
5. Do you have high blood pressure? Yes No
6. Do you have a history of myeloma, sickle cell disease, polycythemia, or pheochromocytoma? Yes No
7. Do you have a history of kidney disease or diabetes? Yes No
8. Do you take Glucophage? Yes No

Your doctor has ordered this C.T. Scan to obtain more information which will aid in the diagnosis of your condition. If you have additional question regarding your exam, please feel free to discuss them with the Technologist or Radiologist prior to your scan.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS THEIR AGENT TO GIVE THE CONSENT TO HAVE THE DESCRIBED PROCEDURE PERFORMED.

Patient Signature of Patient or Guardian: _____ Date: _____