ADVANCED MRI AND IMAGING

2821 US HWY 27 North • Sebring, FL 33870
Phone: (863) 385-8000 • Fax: (863) 385-8002

Diagnostic Study Registration Form (CT with IV contrast)

Patient Name _____Date_____

Date of Birth _____Age _____Weight _____ Height_____Sex: ___Male _____Female

HOME ADDRESS _____ _____

MAILING ADDRESS_____

PRIMARY CARE PHYSICIAN_____

Patient Home Ph _____Patient Cell Phone _____Email_____

AREA TO BE EXAMINED / TYPE OF EXAMINATION:_____

DIAGNOSIS OR CLINICAL SUSPICION_____

Have you had any previous X-Rays, MRIs, CTs, DEXA or Ultrasounds? _____ Yes _____No

If yes: What _____When _____Where_____

_____Yes _____No Have you ever smoked? If yes for how long?_____ How many packs a day?_____ If you are an ex-smoker, how long ago did you quit? _____

H/o Cancer ____YES_____NO If YES What type _____Where_____

Radiation therapy: _____Yes _____No Chemotherapy: _____Yes___ No____

List recent surgeries:_____

IV Contrast History:
Do you have any personal history of:

_____Yes _____No Asthma and/or allergic respiratory disease
_____Yes _____No Lung disease
_____Yes _____No Myeloma _____Yes _____No Proteinuria_____-
_____Yes _____No **Diabetes**

If Diabetic , do you take oral medication containing Metformin_____Yes _____No
_____ Glucophage_____Metaglip _____ Avandamet _____ Riomet _____ Fortamet_____Glucovance

_____Yes _____No Kidney disease _____Yes _____No Kidney surgery
_____Yes _____No Heart disease, CHF, and or high blood pressure
_____Yes _____No Liver disease? _____Yes _____No Liver transplant/pending liver transplant?
_____Yes _____No Seizure disorder? _____Yes _____No Thyroid disorder?
_____Yes _____No Contrast exam performed within the last 7 days?
_____Yes _____No Are you **pregnant**? Date of last menstrual period:_____
_____Yes _____No Are you currently **breast feeding**?

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List any drug /food allergies:_____

Have you ever had **an allergic reaction to x-ray contrast (IODINE DYE)**_____Yes _____No

If yes, please explain:_____

Patients with Diabetes
If you are taking Metformin (Glucophage, Glucovance, etc.) and having a contrast injection in X-ray or CT today, you will be asked to stop taking it for 48 hours post injection of contrast media. This does not apply to MRI contrast injections. Contact your primary physician prior to restarting your Metformin (Glucophage, Glucovance, etc.) to make sure your renal functions are okay.
I will stop my Metformin (Glucophage, Glucovance, etc.) and contact my physician before restarting it.
_____(Initial Here)

IV Contrast Consent

CT examinations often require the use of contrast materials to enhance the visibility of certain tissues or blood vessels. The contrast material may be given as something to drink before your exam, or injected intravenously during your exam. In rare cases, the contrast material may be need to be given in the form of an enema to help visualize the lower colon in the pelvis. The intravenous contrast material contains **IODINE** and some people may be allergic. We screen all of our patients for this prior to administering the intravenous contrast material. We use **non-ionic** contrast material which is proven to be more tolerable. Some reactions such as nausea, vomiting, skin rash, hives, or other more severe reactions can occur, but are very uncommon. With the safety of the new **non-ionic** contrast materials, adverse effects are very rare but can happen.

I have answered the questions on page 1 to the best of my knowledge and understand the information presented to me. I consent to the use of IV Contrast during my exam.

Patient, Parent or Guardian, Responsible Party Signature_____

Date _____Time_____

FOR TECHNOLOGIST ONLY

Technologist _____

Oral contrast given _____Amount_____
IV contrast given: Contrast type _____Amount _____(CC)
Contrast allergy_____Yes _____No
Patient premedicated for exam_____Yes _____No_____
Discharge instructions given for Metformin: _____Yes _____No
Discharge instructions given for nursing mothers ____Yes _____No

AUTHORIZATION/CONSENT FOR DIAGNOSTIC PROCEDURES AND MEDICAL TREATMENT

I, the undersigned patient, or parent , or legal guardian, knowing that I am (or the patient is) suffering from a condition requiring medical care, do hereby consent to such medical care, encompassing routine diagnostic procedures and medical treatment by Advanced MRI and Imaging . I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

Initial

CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent to this practice and all health care providers furnishing care within the practice to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Please be advised that our Notice of Privacy Practices provides more detailed Information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by contacting our Privacy Officer.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the above address. You may deliver your revocation by any means you choose but it will be effective only when we actually receive the revocation. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Initial

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of privacy practices

Initial

FINANCIAL POLICY

I have received, read and understand the financial policy of Advanced MRI and Imaging. I understand that as my medical care provider, Advanced MRI and Imaging relationship and concern is with me and my health, not my insurance company. All charges are my responsibility. On any balance on my account after 90 days, including those that insurance has not paid, collection action may be taken. If it becomes necessary to collect any sum due, through an attorney, then I the patient agree to pay all reasonable costs of the collection, including attorney's fees, whether suit is filed or not.

Initial

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to this provider for all covered medical services and supplies provided to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Sign(Patient or legal guardian):_____

Date:_____

Print Name of Patient:_____Date of Birth:_____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the physician/staff of Advanced MRI and Imaging to send artificial, prerecorded, or automated calls and text messages and to release/leave medical information, with the following (please check applicable):

_____ Spouse

_____ Significant other

_____ Family Member (name: _____)

_____ Caregiver

_____ Answering Machine

_____ Send artificial, prerecorded, or automated calls and test messages.

I understand and acknowledge that should I need to change how I receive my medical information or messages that it will be necessary to notify my provider/office to those changes.

X _____

Signature of Patient (of parent/guardian or minor) Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

FOR OFFICE USE ONLY

Print Name: _____

Signature: _____ Date: _____