



PATIENT INFORMATION			
SS#:	Last Name:	First Name:	
Middle:	DOB:		
Gender:		Marital Status:	
Address:			
City:	State:	Zip:	
Home Phone () -	Cell Phone () -	Work Phone: () -	
Employer:		Occupation:	
Employer Address:			
City:	State:	Zip:	
PRIMARY INSURANCE			
Insurance Company:	ID#:	Group#:	
SECONDARY INSURANCE			
Insurance Company:	ID#:	Group#:	

ATTENTION ALL MEDICARE PATIENTS. Please list all medical insurance policies that you have in addition to Medicare.

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize INVIEW MEDICAL IMAGING to release all information necessary to secure payment from my insurance carrier(s) and Medicare (if applicable).

Signed: _____ Date: _____

PATIENT PRIVACY: Our practice is committed to securing the privacy of your health information. Accordingly, we have provided you with a copy of our practice's *Notice of Privacy Practices*. You are not required to read this notice. However, we would like your acknowledgement that you received this *Notice of Privacy Practices*.

Signed: _____ Date: _____

Free Bone Density Screening!

Risk Factors Include: All women 65+, post menopausal women (with additional risk factor), considering therapy for osteoporosis or women who are currently on hormone therapy (HRT/ERT) for prolonged periods.

YES, I'm interested in receiving a free bone density screening.

Join our mailing list. We do not sell or share our email list with any outside companies. Your email address will only be used to deliver news, discounts and announcements pertaining to InView Medical Imaging.

Email: _____

Precertification & Financial Responsibility: I understand that it is the insurer's responsibility to review anticipated courses of treatment. I understand that if the insurer determines that the treatment plan is necessary and appropriate and issues certification, the benefits of my health plan will be available to me according to my policy terms. However, if certification is denied, benefits may be withheld. I understand that precertification may be the responsibility of the patient or financially responsible party and his or her physician. I also understand that I may be financially responsible for any and all related charges incurred as a result of this treatment plan should the insurer either refuse to precertify the treatment or retrospectively determine that a specific service was inappropriate, or should the certification occur too late to be valid. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company and personal physician in advance of my appointment.

I have read and understand the above consent (Initials)

Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to InView Medical Imaging Center, (IMI), all medical provider benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of charges for this period of service). I authorize and direct the insurance company to pay all such benefits to IMI. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and IMI.

I have read and understand the above assignment (Initials)

Consent to Release Claims Information: I hereby consent for InView Medical Imaging Center, their employees and agents, to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my (or the patient's) medical care and treatment to all appropriate persons for the purpose of treatment, health care operations and evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare), or any private reimbursement which may have a bearing on benefits payable by or on behalf of any such person. I hereby authorize IMI, its employees and agents to act on my behalf in completing claims. I (or the patient) may revoke this consent in writing at any time and all future disclosures will then cease. I (or the patient) may restrict the uses of information with written notice and if agreed to by the IMI the additional limitations are binding.

I have read and understand the above release (Initials)

I HAVE READ AND FULLY UNDERSTAND THE AUTHORIZATIONS, CONSENTS, AND ASSIGNMENTS PRINTED ON THE FRONT AND BACK OF THIS FORM AND FULLY ACCEPT AND CONSENT TO EACH OF THEM.

Patient's Printed Name

Signature of Patient Date Witness

I am legally authorized to provide consent on behalf of the patient listed above. My relationship to the patient is described as follows:

Signature of Authorized Representative Date

Relationship to Patient Witness



CT CONTRAST PATIENT PROFILE

PATIENT'S NAME Last	First

DATE OF STUDY	SEX	WEIGHT lbs.	DATE OF BIRTH	AGE
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DIAGNOSIS or SYMPTOMS (Reason for this exam)	Are you pregnant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure LMP DATE <input style="width: 100px;" type="text"/>
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Have you ever had X-Ray Contrast (Dye) injected before? <input type="radio"/> Yes <input type="radio"/> No	Are you taking Glucophage (Metformin) <input type="radio"/> Yes <input type="radio"/> No Last dose taken: <input style="width: 100px;" type="text"/>
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In order to perform the exam your physician has requested, you will be given an injection of contrast containing iodine. The contrast allows the radiologist to better visualize the area of study.

Non-ionic iodine-related contrast media is considered quite safe. Any injection carries slight risk of harm including injury to a nerve, artery or vein, infection, or reaction to the contrast being injected. Occasionally, a patient will have a mild reaction to the contrast agent and develop sneezing or hives. Uncommonly a serious reaction occurs. The physicians and staff are trained to treat these reactions. Very rarely death has occurred related to contrast administration. A YES answer to any of the questions below does not mean that you will get a contrast reaction as the overwhelming majority of all patients do not.

If you have any questions about the contrast agent, risks, reactions, or the procedure itself, please ask the x-ray technologist or the physician.

Did you have any of the following reactions after a prior contrast injection?

<input type="checkbox"/> Rash	<input type="checkbox"/> Fainting	<input type="checkbox"/> Medical Treatment Required
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Flushing	<input type="checkbox"/> No Problems
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Other <input style="width: 100px;" type="text"/>

Do you have a History of any of the following?

<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Severe Debilitation
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> Hives	<input type="checkbox"/> Single Kidney	<input type="checkbox"/> Multiple Myeloma
<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Kidney Transplant	<input type="checkbox"/> None of These
	<input type="checkbox"/> Diabetes	

Food Allergies: Shellfish None Other

Drug Allergies: Iodine Antibiotics Other

I UNDERSTAND AND ACCEPT THE RISKS OF THE CONTRAST Yes No

Patient Signature	Date
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PROCEDURE DATA This Section to be Completed by Technologist/Nurse

<input type="checkbox"/> Signed consent on chart	IV Access Site Gauge _____ Location <input style="width: 100px;" type="text"/> 1st Attempt <input type="radio"/> Yes <input type="radio"/> No Other attempted sites <input style="width: 100px;" type="text"/>	Contrast Media <input style="width: 50px;" type="text"/> cc's LOCM using power injection	Premedicated <input type="checkbox"/> None <input type="checkbox"/> Steroids <input type="checkbox"/> Benadryl
<input type="checkbox"/> Order verified			

Patient Education

Provided To Patient Family Other Communication/Language Barriers - Explain

Complication Yes No Response Treatment

CONTRAST PATIENT PROFILE E1813 (Revised 12/16/2005)	Completed by: _____ Tech/Nurse Signature: _____
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