INFORMED CONSENT FOR COMPUTERIZED TOMOGRAPHY (CT) WITH OR WITHOUT CONTRAST INJECTION

PATIENT NAME: _____ MED REC #: _____

TO THE PATIENT: You have the right to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you. It is so that you may choose to give or withhold your consent to the procedure.

IF YOU ARE PREGNANT OR THINK THAT YOU MAY BE PREGNANT, PLEASE INFORM THE CENTER PERSONNEL AT ONCE.

Your physician has requested that we perform a computerized tomography scan (CT) to obtain additional information. This is a diagnostic test that involves x-ray images and a computer to produce an image of internal organs to provide detailed information of areas within your body. As part of the test, contrast material may be injected into your vein in order to produce better images of the part of the body being scanned.

Potential Risks: The following complications are possible. Anytime an injection is given, there is potential for pain, bleeding, bruising, or swelling and infection at the injection site. Additional allergic reactions in response to the contrast agent may include hives, shortness of breath, or difficulty swallowing. There have been rare instances of kidney failure, damage or death after the administration of the contrast agent. **It is very important that you inform the technologist if you experience any of the conditions mentioned in this form.**

NOTE TO PATIENTS: If you have previously had a reaction to a contrast injection, such as hives, severe itching, shortness of breath and/or any significant reaction requiring hospitalization, a history of asthma or other allergic conditions, any history of sickle cell anemia or kidney disorder, are pregnant or breast-feeding, or if you are taking Glucophage, you MUST inform the technologist.

An alternative to this procedure may be an ultrasound, x-ray, MRI or no treatment. However, your physician believes the CT to be the best diagnostic test for you, considering your symptoms and condition. The benefit of this exam is to assist your physician with a correct diagnosis.

I (we) certify that I (we) have read it or have had it read to me and that I (we) understand its contents.

I (we) have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used, and the risks and hazards involved.

_____ Date: _____
Patient, Parent or Legal Guardian Signature

_____ Date: _____
Witness Signature

2401 Ira E. Woods, Suite 600 • Grapevine, TX 76051 • (817) 488-9991 • Fax (817) 488-9992

Med Rec # _____

CT & IV CONTRAST HISTORY AND SCREENING FORM

PATIENT INFORMATION

HAVE YOU HAD PREVIOUS X-RAYs, MRIs, CTs, or ULTRASOUNDS RELATED TO YOUR CURRENT PROBLEM OR IN THE REGION OF YOUR PROBLEM ONLY? ☐ YES ☐ NO

WHAT _____ WHEN _____ WHERE _____

Patient Name: _____

DOB _____ Age _____ Sex ☐ Male ☐ Female

Weight _____ Procedure _____ Physician _____

Reason you are here today? _____

CONTRAST HISTORY

List all previous surgeries: _____

List all medications you usually take: _____

List any drug allergies: _____

Are you taking Glucophage? ☐ Yes ☐ No

Have you ever had an allergic reaction to x-ray contrast (dye)? ☐ No ☐ Yes, explain: _____

_____

_____

Any personal history of:

☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Dizziness
☐ Yes ☐ No	Allergic Respiratory Disease	☐ Yes ☐ No	Heart Disease/CHF
☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Stroke
☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Liver Disease
☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Seizure Disorder
☐ Yes ☐ No	Multiple Myeloma	☐ Yes ☐ No	Bladder Disease
☐ Yes ☐ No	Prostate Problems	☐ Yes ☐ No	Headaches
☐ Yes ☐ No	Are you breast feeding?		

If Yes to any of the above questions, please explain: _____

_____

_____ Date: _____

Patient, Parent or Guardian Signature

_____ Date: _____

Witness/Technologist Signature

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ATTENTION PATIENTS

PLEASE READ CAREFULLY BEFORE SIGNING

Payment for your deductible, co-pay and or co-insurance is due and payable at the time of Service, unless prior arrangements have been made.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received, read, understand, and agree to Eclipse Imaging and Pain Management Center's Notice of Privacy Practices.

FILM RETENTION POLICY

I understand that Eclipse Imaging and Pain Management Center maintains my films electronically and I must give a 24-48 hour notice if I need my films printed. If additional copies of films are requested, a fee may apply.

PRINT NAME OF PATIENT: _____

Signature: _____ Date: _____

Relationship to Patient ☐ Self
☐ Parent or Legal Guardian (if patient is under 18)

Cancellation will be effective upon receipt at the following address:
Eclipse Imaging and Pain Management Center
2401 Ira E. Woods, Suite 600
Grapevine, TX 76051
Office: (817) 488-9991
Fax: (817) 488-9992

PLEASE READ CAREFULLY BEFORE SIGNING

Consent for Disclosure

I hereby give consent to Eclipse Imaging and Pain Management Center and all of its healthcare providers furnishing care within Eclipse Imaging and Pain Management Center's facilities to use, disclose, and/or acquire my protected health information for the purposes of treatment, payment and healthcare operations.

I realize I may cancel this consent at any time. I understand my cancellation must be in writing, signed by me or on my behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but it will only be effective when it is actually received. Cancellation will not be effective to the extent that Eclipse Imaging and Pain Management Center has acted in reliance upon this consent.

I have the right to request restriction on the usage and disclosure of the protected health information for the purposes of treatment, payment, or health care operations.

Eclipse Imaging and Pain Management Center's privacy policy provides more detailed information about the usage and disclosure of my protected information. I have the right to review the privacy policy before signing this consent.

Eclipse Imaging and Pain Management Center reserves the right to amend the terms of the privacy policy. I may obtain a current copy of the policy by requesting it at 817-488-9991.

I specifically give permission for Eclipse Imaging and Pain Management Center to disclose my protected health information, which includes discussion of the findings of any tests I may have had with _____.
(Person's Name)

PRINT NAME OF PATIENT:_____

Signature:_____Date:_____

Relationship to patient: ☐ Self
☐ Parent or legal guardian if patient is under 18

CANCELLATION

I hereby void consent given above.

PRINT NAME OF PATIENT:_____

Signature:_____Date:_____

Relationship to patient: ☐ Self
☐ Parent or legal guardian if patient is under 18

Cancellation will be effective upon receipt at the following address:
Eclipse Imaging and Pain Management Center
2401 Ira E. Woods, Suite 600
Eclipse, Texas 76051
Fax: 817-488-9992

REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Widowed

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security	Home # ( ) Cell # ( )

P.O. Box	City	State	ZIP Code

Email Address	Occupation	Employer	Employer Phone No.

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )

Occupation	Employer	Employer Address	Employer Phone No. ( )

Name of Primary Insurance	Subscriber's Name	Group #	Policy #

Subscriber's S.S. #	Birth Date / /	Work Comp #	Date of Injury	Work comp contact	Contact info.

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

Medicare Patient Agreement

Request that payment of authorized Medicare benefits be made either to me or on my behalf to Eclipse Imaging and Pain Management Center for any services furnished me by that provider. I authorize any holder of medical information about me to be released to the Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. This authorization is in effect until I choose to revoke it in writing.

Assignment of Benefits/Medical Release/Consent for Treatment/Acknowledgement of Notice of Privacy Policy

With this form I acknowledge I have the right to review and request a copy of the NOTICE OF PRIVACY from Eclipse Imaging and Pain Management Center and I authorize the release and disclosure of portions of my medical record necessary to obtain reimbursement for myself and /or for my covered dependents. This authorization gives Eclipse Imaging and Pain Management Center the right to request and receive medical information from other health care entities and providers to include but not limited to copies of lab results, diagnostic test reports, films/images, and other clinical information deemed necessary by Eclipse Imaging and Pain Management Center, physicians or representatives. I understand I am not required to sign this authorization as a condition or my treatment, unless permitted by law. I also understand that I may inspect my protected health information, request more information, and revoke this authorization, as permitted by the federal privacy regulations and in accordance with Eclipse Imaging and Pain Management Center privacy policy. I hereby consent to any medical treatment, x-ray, laboratory or other procedure, which the physician(s) may consider or advise in treatment of my case (or as legal guardian for patient). I hereby authorize any benefits due to be paid directly to Eclipse Imaging and Pain Management Center 5750 Rufe Snow Dr. Ste 108 North Richland Hills, Texas 76180. This agreement will remain in effect until I choose to revoke it in writing. I understand that I am seeing Eclipse Imaging and Pain Management Center and, as a courtesy, the office will be billing my insurance company, However, I so understand that should my insurance company send the payment to me, I will forward the payment within 48 hours to Eclipse Imaging and Pain Management Center. I also understand that should I not send the payment to the office and the office has to proceed with the collection process; I will be responsible for any cost incurred by the office to retrieve their moneys. I also understand that the office may have to report said payment to the Internal Revenue Service as income. I herby authorize my insurance company to pay my benefits directly to Eclipse Imaging and Pain Management Center and I understand that I will be fully responsible for any outstanding balance on my account. The information that I have provided to Eclipse Imaging and Pain Management Center is true and correct in its entirety.

Payment

Payment for your deductible, co-pay and/or coinsurance is due and payable at the time of service, unless prior arrangements have been made. The patient or responsible party also agrees to pay for any services not covered by the patient's or guarantor's insurance or health plan.

Film Retention Policy

I understand that Eclipse Imaging and Pain Management Center maintains my films electronically and I must give a 24-48 hour notice if I need my films printed. Any requests for films less than 24 hour notice will be put on a CD. If additional copies of films are requested, a fee may apply.

X Date Relationship to Patient