



## INFORMED CONSENT FOR X-RAY

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 involve. 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 an x-ray to obtain additional information. X-ray produces images of the internal body parts being examined. X-ray is painless, however, radiation is emitted. Therefore, it is critical for you to inform center personnel if there is any possibility you could be pregnant. Because the x-ray is a diagnostic procedure, it provides information that may aid your physician in diagnosing and treating your medical condition. Without the x-ray, accurate diagnosis and proper treatment may be delayed.

If you are having a fluoroscopic procedure, a contrast agent may be injected into your vein in order to produce better images of the part of your body that is being examined.

POTENTIAL RISKS – The following complications are possible anytime an injection is given, there is potential for pain, bleeding, bruising or swelling at the injection site. Exams requiring contrast may result in a mild headache, nausea, itching or other vague symptoms for a short time after the injection. Additional allergic reactions in response to the contrast agent may include hives, shortness of breath or difficulty swallowing. There have been rare instances of death after the administration of the contrast agent. It is very important to inform the technologist if you experience any of the conditions mentioned in this form.

NOTE TO PATIENTS: If you 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 anemia, sickle cell anemia, or kidney disorder, are pregnant or breast feeding you MUST inform the technologist.

There may be other imaging alternatives; however, your physician believes the x-ray to be the best diagnostic test for you, considering your symptoms and conditions. The benefit of this exam is to assist your physician with a diagnosis.

I (WE) CERTIFY THIS FORM HAS BEEN FULLY EXPLAINED TO ME, THAT I (ME) HAVE READ IT OR HAVE HAD IT READ TO ME, THAT THE BLANK SPACES HAVE BEEN FILLED IN 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 AND I (WE) BELIEVE THAT I (WE) HAVE SUFFICIENT INFORMATION TO GIVE THIS INFORMED CONSENT.

\_\_\_\_\_  
Patient/Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date



DATE \_\_\_\_\_

NAME \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_

Legal Name As It Appears on Insurance Card

**PHYSICIAN (S) TO SEND REPORT TO:**

ORDERING PHYSICIAN: \_\_\_\_\_ MD / DO \_\_\_\_\_

OTHER: \_\_\_\_\_ MD / DO \_\_\_\_\_

**BREAST/MEDICAL HISTORY**

**HAVE YOUR OVARIES BEEN REMOVED? YES / NO**

ESTROGEN (EX. PREMARIN) \_\_\_\_\_ FOR HOW LONG? \_\_\_\_\_

PROGESTIN (EX. PROVERA) \_\_\_\_\_ FOR HOW LONG? \_\_\_\_\_

BIRTH CONTROL PILLS \_\_\_\_\_ FOR HOW LONG? \_\_\_\_\_

.....  
**HAVE YOU HAD ANY CANCER OTHER THAN BREAST CANCER? \_\_\_\_\_ WHAT TYPE? \_\_\_\_\_**

**INDICATE IF YOU HAVE A FAMILY HISTORY OF BREAST CANCER IN YOUR:**

MOTHER \_\_\_\_\_ GRANDMOTHER \_\_\_\_\_ SISTER \_\_\_\_\_ DAUGHTER \_\_\_\_\_

**AGE WHEN DIAGNOSED:** \_\_\_\_\_

.....  
**HAVE YOU HAD ANY OF THE FOLLOWING:**

**RIGHT LEFT WHEN/AGE**

IMPLANTS \_\_\_\_\_

REDUCTION \_\_\_\_\_

SURGICAL BIOPSY \_\_\_\_\_

NEEDLE BIOPSY \_\_\_\_\_

CYST ASPIRATED \_\_\_\_\_

SUBCUTANEOUS MASTECTOMY \_\_\_\_\_

MASTECTOMY FOR BREAST CANCER \_\_\_\_\_

LUMPECTOMY FOR BREAST CANCER \_\_\_\_\_

**HAVE YOU HAD A PREVIOUS MAMMOGRAM? YES / NO WAS IT DONE HERE? YES / NO**

**NAME OF IMAGING CENTER \_\_\_\_\_ LOCATION \_\_\_\_\_**

**WHEN WAS YOUR LAST MANUAL BREAST EXAM BY A PHYSICIAN OR NURSE? \_\_\_\_\_**

**DO YOU HAVE ANY CURRENT PROBLEMS THAT YOU OR YOUR PHYSICIAN ARE CONCERNED? YES / NO**

**RIGHT LEFT OTHER: \_\_\_\_\_**

LUMP \_\_\_\_\_

PAIN \_\_\_\_\_

NIPPLE DISCHARGE \_\_\_\_\_



**THE FOLLOWING INFORMATION IS VERY IMPORTANT FOR OUR PATIENTS TO KNOW. PLEASE READ AND SIGN. IF YOU HAVE ANY QUESTIONS, PLEASE ASK.**

Mammography is the most sensitive screening test available to detect breast cancer, although; it has been proven to be able to reduce breast cancer mortality by at least one-third MAMMOGRAPHY IS NOT ACCURATE 100% OF THE TIME.

Some of the reasons breast cancers may be missed are:

1. **BREAST COMPOSITION** – The denser your breasts are the harder it is for mammography to detect masses. Denseness in the breast is the amount of fibrous and milk gland tissue relative to the amount of fat. Breasts tend to become less dense with age.

*Texas H.B. 2012 – Henda’s Law states that the following information is to be conveyed (verbatim) by the mammography facility to each woman on completion of a mammogram in Texas:*

If your mammogram demonstrates that you have dense breast tissue, which could hide abnormalities, and you have other risk factors for breast cancer that have been identified, you might benefit from supplemental screening test that may be suggested by your ordering physician.

Dense breast tissue, in and of itself, is a relatively common condition. Therefore, this information is not provided to cause undue concern, but rather to raise your awareness and to promote discussion with your physician regarding the presence of other risk factors, in addition to dense breast.

A report of your mammogram results will be sent to you and your physician. You should contact your physician if you have any questions or concerns regarding this report.

2. **COMPRESSION** – Compression is necessary for good mammography and to reduce the amount of radiation that you receive. If your breasts are so tender as to allow only mild compression accuracy maybe decreased.
3. **BREAST CANCER TYPE** – There are several types of breast cancer. Although many breast cancers can be detected when they are no bigger than a grain of sand, unfortunately, a few may grow very large and not produce any suspicious abnormality on the mammogram. Some cancers produce mammographic findings but are not suspicious initially. Finally, some breast cancers mimic non-cancerous abnormalities in every way, both mammographically and physically.
4. **IMPLANTS** – The presence of implants reduce mammographic accuracy, particularly if they are hard from scar formation. (RE: Rupture – The compression used for mammography could cause rupture of an implant. This is an unlikely event but the possibility is real, particularly for older implants whose walls have thinned. Only the amount of compression needed for diagnostic images will be applied, but no guarantee can be made concerning rupture. If you have any concerns have them addressed to your satisfaction prior to proceeding with mammography.)

Because neither mammography nor any medical test can be relied upon to detect all breast cancers, women are strongly encouraged to practice regular monthly breast self-examinations. Even if your examination today reveals nothing statistically suspicious, if you or your doctor remains concerned about any breast abnormality, or you become concerned after today, you are advised to have additional evaluation or to seek another opinion promptly.

**I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



**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

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**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	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Widowed	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former Name)		Birth Date / /	Age
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		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of Secondary Insurance (if applicable)		Subscriber's Name		Group #	Policy #	
Patient's Relationship to Subscriber		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> 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. (    )
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### 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 hereby 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