MRI & CT
Outpatient Imaging Center of Springfield

CT PATIENT QUESTIONNAIRE

PATIENT NAME: _____ DOB: _____

CT Study for Today: _____ DOI: _____

ORDERING PHYSICIAN: _____ DATE: _____

GENERAL MEDICAL HISTORY

REASON FOR TODAYS EXAM: _____

Do you have a history of surgery in area being scanned? If so, what and when? _____

_____

Is there **any chance** you may be pregnant? **YES NO** If yes, inform the technologist. Date of last menstrual _____

Are you nursing an infant? **YES NO** **If yes, stop nursing for 48 hours after contrast injection**.

Do you have a history of Breast Cancer? **YES NO** Are you on dialysis? **YES NO**

Have you had an asthma attack in the last 24 hours? **YES NO** Do you use an asthma inhaler or medication every day? **YES NO** Have you ever been hospitalized for asthma? **YES NO** Have you ever had a severe allergic reaction to anything requiring hospitalization, a breathing tube or epinephrine? **YES NO**

CONTRAST ALLERGY AND STERIOD PREMEDICATON HISTORY

Is this the first time you have ever received CT/X-Ray contrast (dye) material? **YES NO** Have you had an allergic reaction to CT/X-Ray contrast/dye? **YES NO** If yes please describe: _____

Have you ever been instructed to take a steroid medication in preparation for a CT/X-ray with contrast/dye? **YES NO**

If yes, have you taken a steroid medication in preparation for today's exam? **YES NO**

List any additional medication allergies: _____

KIDNEY FUNCTION HISTORY

Do you have diabetes treated with insulin or other medications? **YES NO** Do you have a family history of kidney failure? **YES NO** Do you have a family history of kidney disease including tumor or transplant? **YES NO**

Do you have a history of paraproteinemia, e.g. multiple myeloma? **YES NO** Do you have a history of collagen vascular disease, e.g. scleroderma or lupus? **YES NO** Have you had prior kidney surgery? **YES NO**

Do you take drugs containing METFORMIN (Glucophage or Glucovance)? **YES NO** If you are unsure, speak with the technologist.

Do you take non-steroidal anti-inflammatory (aspirin like) drugs chronically or in high doses? **YES NO**

Do you regularly take medications that can cause kidney injury? **YES NO**

If you answered yes to any of the above, have you had a renal function test (creatinine blood tests) in the last 30 days?

YES NO DATE OF LABS _____ CREATININE _____ GFR _____

CREATININE ABOVE 1.5 DISCUSSED WITH RADIOLOGIST BY: _____

Date and Time: _____ Remarks: _____

CARDIAC AND THYROID HISTORY:

Do you have angina or congestive heart failure? **YES NO**

Do you have severe aortic stenosis? **YES NO**

Do you have primary pulmonary hypertension? **YES NO**

Do you have severe cardiomyopathy? **YES NO**

Do you have thyroid cancer? **YES NO** If yes, do you expect to receive radioactive iodine in the next few weeks? **YES NO**

Do you have Myasthenia Gravis**? YES NO**

Technologist: Please Circle the type of contrast you are using today

Intravenous Contrast – Your physician has requested that we perform a computerized tomography (CT) scan. In certain cases the radiologist may determine that the usefulness of your CT scan may be improved by administering intravenous iodinated contrast. Most patients experience no unusual effects from this injection other than some warmth or minimal flushing which is very common. As with the injection of any medicine or drug however, a few risks are involved, most of which are mild and momentary: slight nausea, or medicinal or metallic taste in the mouth. There can also be minor reactions such as itching, sneezing or hives. Uncommonly there can be more serious reactions including kidney failure, thrombophlebitis, skin necrosis, and in extremely rare cases death. Medications are on hand to immediately treat these unusual reactions. In ordering this study, your doctor has determined that the diagnostic information which is provided outweighs the risk (usually minimal) of the procedure. The Radiology personnel can answer any specific questions you may have.

Oral Contrast – I understand if I am having ORAL CONTRAST for my exam today. I attest I have not eaten for at least 4 hours, and I have not had anything to eat or drink after I was given my medication.

Printed Patient Name: _____

Signature of Patient or Legal Guardian: _____ Date: _____

Signature of Technologist: _____ _____ Oral Contrast _____ml

Patient Information Form

Name: Date of Birth:

Address: Marital Status:

City: State: Zip: Student Status:

Home Ph: Cell: Gender:

SS#: Email:

Emergency Contact: Phone:

Referred By: Allergies:

Employer: Supervisor:

Address: Work Ph:

City: State: Zip:

Primary Care Physician: Phone:

Responsible Party

Name: Gender: Date of Birth:

Address: Marital Status:

City: State: Zip: Student Status:

Home Ph: Employer:

Work Ph: SS # if not Patient:

Insurance

Primary Insurance: Secondary Insurance:

Insured: Phone: Insured: Phone:

Patient Relationship: Patient Relationship:

Insured ID #: Insured ID #:

Group #: Group #:

I Request Decline a copy of the Privacy Policy

Previous Patient Yes No Paid Check Cash CC Amount Pd

Authorization

I hereby authorize release of information necessary for my insurance company to process my claim. The above information is correct to the best of my knowledge.

I hereby authorize payment directly to MRI of Springfield insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not paid in a timely manner by my insurance.

Signed: Date:

ACKNOWLEDGEMENT OF MEDICAL RECORDS POLICY

MRI of Springfield will provide one original set of images to you or your Physician in the event they are needed for follow up appointments.

If you are not taking your images with you, it is your responsibility to inform MRI of Springfield of any appointment dates/times in which the images would be needed for other doctors and or facilities. **MRI of Springfield requires 24 hour advance notice in order to have images/medical records available for pickup without any delay. If you show up to pick up images without notice, please note that there will be up to a 30 minute wait to produce a CD for you.**

I understand I will be responsible for my images on CD if I take them with me today. I further understand it is my responsibility to maintain the copy of my images for future appointments.

I further understand that if I want/need additional copies of reports and/or images generated through this office there will be a $10.00 medical records fee.

_____

Printed Name

_____

Signature of Patient or Patients Representative Date

_____

Images will be taken by patient on day of service ____YES ____NO

Verified by Staff Member _____

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS, ASSIGNMENT AND RELEASE FOR PAYMENT.

I consent to the use or disclosure of my individually identifiable health information as described.
I understand that my individually identifiable health information may be used and disclosed to carry out treatment, payment or health care operations. I understand that the Notice of Privacy Policies provides a more complete description of the types of uses and disclosures and that I have the right to review the notice before signing this consent. I further understand that the terms of the notice may change, and any changes will be mailed upon receipt of a written request.

I understand that I may request that the covered entity (MRI of Springfield) restrict how my individually identifiable health information is used or disclosed to carry out treatment, payment or health care operations. MRI of Springfield is not required to agree to requested restrictions, but if MRI of Springfield agrees to a requested restriction the restriction is binding. I understand that I may revoke the consent at any time by notifying the covered entity in writing, except to the extent that MRI of Springfield has taken action in reliance on the consent.

I request that payment of authorized Insurance Company benefits be made to MRI of Springfield for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment to benefits apply.

I understand that as part of my health care, MRI of Springfield originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnoses and information to my bill, a means by which third-party-payors can verify that services billed were actually provided, and a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I certify that I (or my dependents) have insurance coverage and I have supplied the correct insurance card & information. **I assign directly to MRI of Springfield, Inc., all insurance benefits, if any, otherwise payable to me for services rendered**. **If I do not have insurance, I agree to pay in full the amount agreed upon by me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions**. **If I default on my payments, I understand I will be responsible for all costs of collection, including reasonable attorney's fee, court costs, any late fee charges, and interest on all sums due at the annual rate of 18% without necessity of demand and whether or not suit is actually filed. I understand that such a lawsuit and/or property lien or garnishment of wages, shall and will be filed in Greene County, Missouri.**

I hereby authorize MRI of Springfield (the covered entity) to provide any and all documentation from my file, whether or not it is considered protected health information (PHI) by the Health Insurance Portability and Accountability Act of 1996 or otherwise, in the instance that I or my insurance company do not pay the total sums owed to MRI of Springfield, and it becomes necessary for litigation to be filed against me in order to collect upon those sums. I also hereby authorize any protected health information necessary to file such litigation be released to attorneys for MRI of Springfield as attachments to the litigation documents themselves. I understand that said documents may constitute protected health information and hereby forever discharge and release MRI of Springfield and their attorneys from any liability of any kind for any alleged breach of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____

Signature of Patient or Patient's representative Relationship to Patient

_____

Printed Name of Patient or Patient's Representative Date

_____ I request a copy of the HIPAA notice _____ I decline a copy of the HIPAA notice

MRI of Springfield, Inc. Authorization for Use and Disclosure of Protected Health Information

Printed Name: _____ DOB: _____

Address:_____

Social Security Number: _____ Phone Number: _____

Information of Images & Reports to be released for this exam: From(date): _____To (date): _____

MRI_____ Images___ Report___ CT_____ Images___ Report___

Other_____ Images ___Report___

Purpose of request: Treatment ___ Patient Request___ Billing/Claims___ Other _____

I, the undersigned authorize and request MRI of Springfield to:

Obtain Information from: _____
Name Phone/Fax Number

Release Information to: _____
Name Phone/Fax Number

Drug and or Alcohol Abuse, and /or Psychiatric, and/or HIV/AIDS Records Release
I understand that my medical or billing record may contain information in reference to drug and or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS testing and or treatment, and/or other sensitive information and I agree to its release.

Time Limit & Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at 1420 E. Bradford Parkway, Springfield, MO 65804. Unless revoked, this authorization will expire 1 year from date of signature unless otherwise specified.

Re-Disclosure
I understand that once information is released to the above named person or persons, my information may be subject to re-disclosure. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless it is for research related treatments or provided solely to give information as **specified under Purpose of Request**. I can inspect or copy the protected health information specified above.
I understand that if I authorize the release of Drug & Alcohol abuse treatment records, that those records are protected by Federal Law. The Authorization for release of information form does not authorize re-disclosure of medical records protected by this law from being re-disclosed even to the patient, without the specific written consent to the patient or as otherwise permitted by such law and or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Federal rules restrict any use of the information for criminal investigations or prosecutions of any alcohol or drug abuse patient.

_____
Printed Name of Patient or Guardian Date

Signature of Patient or Patient Guardian: _____

Identity of Requester verified via: Photo ID _____ Matching Signature _____ Other _____
(Describe)

Verified by: _____

Doc 5 revised 6/17/14