CHARTER RADIOLOGY
WHERE COMPASSION AND EXPERTISE COME TOGETHER

SCAN+ NOT SUPPORTED

CT/CTA Screening Form

Name: DOB: Age: Weight: Height: Sex:

Reason you are here today? Explain your medical problem in detail.

Patient History

Question	Select Yes or No
Have you had previous imaging related to your symptoms? **If Yes- When**: _____ **Where**: _____	☐ YES ☐ NO ☐ N/A
Have you had surgery to the body part being imaged? If yes, please describe: _____	☐ YES ☐ NO
Do you have history of Cancer or Tumors? If yes, please describe: _____	☐ YES ☐ NO
Is there a chance you may be pregnant? Date of last menstrual period: _____	☐ YES ☐ NO ☐ N/A
Do you have personal or family history of heart disease? If yes-Who: _____ What type: _____	☐ YES ☐ NO
Do you have hypertension or high blood pressure?	☐ YES ☐ NO
Do you have a history of smoking? (Past or Present) If yes, please describe: _____	☐ YES ☐ NO
Do you live an active lifestyle? (at least 30-60 minutes per day)	☐ YES ☐ NO
Are you diabetic?	☐ YES ☐ NO
CIRCLE ONE: gallbladder removed or appendix removed	☐ YES ☐ NO
CIRCLE ONE: Uterus removed or ovaries removed	☐ YES ☐ NO

I acknowledge that all the information given is accurate and thereby consent to have the CT procedure performed on me.

Signature of Patient or Authorized Representative Date

Charter Radiology Technologist Date

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CT Contrast Consent

Your physician has requested that we perform a Computed Tomography (CT) scan. In certain cases the radiologist may determine that the quality of your CT scan may be improved by administering intravenous iodinated contrast agent. Most patients experience no adverse effects from this injection other than a feeling of warmth or flushing which is very common. As with the injection of any medicine or drug, a few risks are involved, most of which are mild and will pass after a few moments: pain, bleeding, bruising at the injection site, slight nausea, or a metallic taste in the mouth. There can also be minor reactions such as itching, sneezing, or hives. Uncommonly, there can be more severe reactions including kidney failure, thrombophlebitis, skin necrosis, and in extremely rare cases, death. The safety of its use in pregnant women has not yet been determined. If you are breast-feeding, you should pump and discard your breast milk for a 48-hour period following this test. It is safe to resume breast-feeding 48 hours after this test.

Please answer the following questions:	**Select Yes or No**	
Have you ever had IV contrast (X-ray dye) before?	☐ YES	☐ NO
Are you allergic to IV contrast (X-ray dye)?	☐ YES	☐ NO
Do you have a history of renal insufficiency/kidney problems/dialysis	☐ YES	☐ NO
Are you diabetic?	☐ YES	☐ NO
If Yes-Do you take any medications containing Metformin?	☐ YES	☐ NO
Do you have a history of thyroid disease?	☐ YES	☐ NO
If Yes-Please describe:_____		

I have read, had the opportunity to ask questions, and understand the above information and give consent for the administration of intravenous contrast and/or oral contrast as indicated.

Patient's Name (printed) Date of Birth Age Patient ID

Signature of Patient or Authorized Representative Date

Charter Radiology Technologist Date

CHARTER RADIOLOGY

PATIENT INFORMATION & BILLING AUTHORIZATION

PATIENT: _____

Last Name First Name Middle Name

_____

Sex Date of Birth

ADDRESS: _____

Street City State Zip Code

PHONE: _____

Home Phone Cell Phone ****E-MAIL FOR PATIENT PORTAL****

INSURANCE: _____

Company Policy Number Group Number

_____

Name of Policy Holder Date of Birth Policy Holder Sex

Secondary: _____

Secondary Policy Number Group Number

_____

Name of Policy Holder Date of Birth Policy Holder Sex

Referring provider(s): _____

List primary care physician or any other doctors to receive your reports: _____

(First and last name)

(____) **MEDICARE (initial if you are covered by Medicare)** I request that payment of authorized Medicare benefit be made to CHARTER RADIOLOGY LLC for any services they furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the Medicare allowed amount. The patient is responsible only for the deductible, coinsurance, and any non-covered services. Coinsurance and the deductible are based on the charge determination of Medicare Carrier.

(____) **MEDICAL INSURANCE (initial if you are covered by any medical insurance. This also includes Medigap, Worker's Compensation or Personal Injury Protection benefits/Auto)** I authorize payment of medical benefits, otherwise payable to me, to CHARTER RADIOLOGY, LLC. I understand that I am financially responsible for charges not covered by this assignment. I authorize Charter Radiology LLC to release to my insurance company any medical information for processing of a claim. I authorize Charter Radiology LLC to obtain information pertaining to my insurance coverage and benefits from the carrier of same. I permit a copy of this authorization to be used in place of the original.

Date **Signature** of patient or parent (if under age 18)

Print full name of responsible party if patient is a minor

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this form, I acknowledge that I can request a copy of Charter Radiology's Notice of Privacy Practices which provides information about ways my protected health information ("PHI") may be used and disclosed by Charter Radiology and states my rights with respect to my PHI. I understand that Charter Radiology has the right to revise these practices and if the terms of the Notice of Privacy Practices change, a revised Notice will be made available to me. Please note: In accordance with Maryland Law, we may destroy patient charts 6 years after the last documented record. In the case of a minor, records, must be retained until the patient reaches the age of 18 plus 3 years, or for 5 years after the record was made, whichever is later.

In addition, by signing this form, I hereby voluntarily authorize the use and/or disclosure of all or any part of my PHI as described in this Authorization by Charter Radiology and its employees, agents, and third parties acting on its behalf as follows: (1) anonymous images of me may be used by Charter Radiology for teaching or educational purposes and (2) in order to facilitate the healthcare services provided to me, Charter Radiology may engage in the following:

- Call, email or send a text to me to confirm appointments Yes____ No____
- Leave a message on my home answering machine and/or cell phone Yes____ No____
- Discuss my medical condition with the following individuals: (i.e. relative or friend)

Name of Individual	**Phone Number**	**Email Address**
_____	_____	_____

My signature below means that I understand and agree to the following:

- My PHI may be protected by law. My PHI that is disclosed under this Authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations.
- Charter Radiology will not condition my treatment on whether I sign this Authorization.
- Without my signature below, this Authorization will not be honored.
- I may receive a copy of this form if I ask for it in writing addressed to Charter Radiology.
- This authorization will expire six (6) years from the date set forth below, unless I revoke it sooner. If I sign this form, I may revoke this Authorization at any time by notifying Charter Radiology in writing at the address below. Revoking this Authorization will not have any effect on actions that Charter Radiology took in reliance on the Authorization before it received notice of my revocation.

_____ _____

Signature of Individual or Representative Date

_____ _____

Printed Name of Individual Relationship to Individual (if signed by Personal Representative)