CT PATIENT HISTORY & SCREENING

Priority Radiology

Exam ordered:_____ Referring physician:_____

Symptoms:_____

(Check one)

Yes	No	
		Have you had a previous imaging study that required an injection of contrast media (dye)?
		If yes, did you experience any difficulties from the contrast injection?
		History of kidney disease

Do you have any of the following?

Yes	No	
		Asthma/hay fever
		Allergies to latex **PLEASE NOTIFY OUR STAFF IF YOU HAVE A KNOWN ALLERGY TO LATEX SO THAT WE MAY USE THE APPROPRIATE GLOVES AND TAPE*
		Congestive heart failure
		Diabetes **Are you taking Glucophage? Y or N**
		Fibrillation and/or fluter of the heart
		Heart disease or heart problems
		Hypertensive heart disease (high blood pressure)
		Hypertensive heart and renal (kidney) disease
		Myocardial infarction (heart attack)
		Multiple myeloma
		Pulmonary heart disease
		Renal (kidney) failure
		Respiratory failure
		Severe arrhythmia (irregular heart beat)
		Sickle cell disease
		Stroke
		Tachycardia (an abnormally high heart rate)
		Unstable angina
		Angina pectoris (severe constricting pain in the chest)
		Generalized severe debilitation Describe:

Please list **ALL** of your allergies below (medicine, food, other):

1._____

2._____

3._____

4._____

Please list **ALL** medications you are currently taking below:

1._____

2._____

3._____

4._____

Patient Signature:_____ Date:_____

TECHNOLOGIST USE ONLY:

Patient status: Debilitated or Ambulatory		BP	Wt
Patient pre-medicated: Y or N		Fasting? Y or N	
Contrast injected:		Injection site:	
Volume:	Time: AM/PM	Technologist:	
Complications/Additional Notes:			

PATIENT SCREENING FORM

PATIENT NAME _____ DATE _____

YES	NO	
_____	_____	History of kidney disease as an adult, including tumor or transplant.
_____	_____	Family history of kidney failure.
_____	_____	Personal history of diabetes for 2 yrs or longer.
_____	_____	Family history of diabetes.
_____	_____	Personal history of rheumatoid arthritis, lupus, or scleroderma.
_____	_____	Personal history of Cardiac disease.
_____	_____	Currently on chemotheraphy.
_____	_____	50 yrs of age or older.

Currently taking the following medications:

YES	NO		YES	NO	
_____	_____	Advil / Motrin	_____	_____	Indocin
_____	_____	Daypro	_____	_____	Feldene
_____	_____	Relafen	_____	_____	Vioxx
_____	_____	Celebrex	_____	_____	Anaprox
_____	_____	Lodine	_____	_____	Clinoril
_____	_____	Naprosyn	_____	_____	Nalfon
_____	_____	Orudis	_____	_____	Tolectin
_____	_____	Ponstel	_____	_____	Toradol
_____	_____	Arthrotec	_____	_____	Meclomen
_____	_____	Voltaren	_____	_____	Ansaid
_____	_____	Cataflam			

Currently taking the following IV antibiotics such as:

YES	NO	
_____	_____	Amikin
_____	_____	Garamycin
_____	_____	Nebcin

PAYMENT AGREEMENT, RELEASE OF FILMS AND MEDICAL RECORDS, & MEDICARE, MEDICAID OR INSURANCE PAYMENT AUTHORIZATION

In consideration of services to be rendered by Priority Radiology, I (we) agree to pay Priority Radiology charges as are ordered by the attending physician in accordance with the terms and policies of Priority Radiology. I hereby authorize and direct Medicare, Medicaid, and/or my insurance carrier(s) to pay directly to Priority Radiology any benefits due me under my plan.

In the event that insurance authorization has not been obtained or it has been denied, I understand I am financially responsible to Priority Radiology for charges not covered and agree that in the event the account is not paid in 60 days of the date of services to pay reasonable attorney's fees if this account is placed in the hands of an attorney for collection.

I authorize the medical treatment and diagnostic imaging of me, my child or my ward by Priority Radiology, its agents and employees.

I authorize the release of films and/or medical records to and/or from Priority Radiology that may be needed for my continuing medical care and information to Medicare, Medicaid and/or my insurance carrier(s) necessary for the reimbursement of services.

I also acknowledge that Priority Radiology cannot assume responsibility for money, clothing or articles of value left in the facility.

If you do not hear from your referring doctor regarding your test results within one week, please contact their office to follow up.

Emergency Contact _____ Relationship _____ Day Time Phone#_____

☐ I have received a Notice of Privacy Practices from Priority Radiology.

☐ Yes, you may contact me at my work phone regarding my examination at Priority Radiology

Date _____

Patient signature_____

By _____
Patient Representative/ Parent / Guardian

Address _____

Relationship to Patient _____

Reason patient cannot sign _____

Witness_____

Priority Radiology
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NOTICE OF PRIVACY PRACTICES

PRIORITY RADIOLOGY HAS A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

All employees,staff, doctors, health professionals and other personnel are legally required to and must abide by the policies set forth in this notice,and to protect the privacy of your healthinformation. This "protected health information," or PHI for short,includes information that can be used to identify you. We collect orreceive this information about your past, present or future health condition to provide health care to you, or to receive payment for this health care. We must provide you with this notice about our privacy practices that explains how, when and why we use and disclose (release) your PHI. With some exceptions, we may not use or release any more of your PHI than is necessary to accomplish the need for the information. We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes to this notice will apply to the PHI already in existence. Before we make any change to our policies, we will promptly change this notice and post a new notice in our lobby.

WE MAY USE AND RELEASE YOUR PROTECTED HEALTH INFORMATION for many different reasons. For some of these reasons, we will need your permission or a specific, signed authorization. Below, we describe the different categories of when we use and release your PHI and give you some examples of each category.

A. WE MAY USE, OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT,OR HEALTH CARE OPERATIONS.

1. For treatment. We may release your PHI to physicians, nurses, medical students, and other health care personnel and agencies who provide or are involved in your health care. For example, if you are being treated for a knee injury, we may release your PHI to the physical rehabilitation department in order to coordinate your care.

2. To obtain payment for treatment. We may use and release your PHI in order to bill and collect payment for services provided to you. It is important that you provide us with correct and up-todate PHI. For example, we may release portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also release your PHI to our business associates, such as attending medical staff, billing companies, claims processing companies and others that process our health care claims.

3. To run our health care business. We may release your PHI in order to operate our facility in compliance with healthcare regulations. For example, we may use your PHI to review the quality of our services and to evaluate the performance of our staff in caring for you.

B. WE ALSO DO NOT REQUIRE YOUR CONSENT TO USE OR RELEASE YOUR PHI:

1. When requested by federal, state, or local law; judicial or administrative proceedings; or law enforcement agencies. We release your PHI when a law requires that we report information to government agencies and law enforcement personnel, for example, about victims of abuse, neglect, or domestic violence; when dealing with gunshot and other wounds; or when ordered in a judicial or administrative proceeding.

2. For public health activities. We report information about births, deaths, and various diseases to government officials in charge of collecting that information and we provide coroners, medical examiners and funeral directors necessary information relating to an individual's death.

4. To avoid harm. In order to avoid a serious threat to health or safety of a person or the public, we may provide your demographic PHI to law enforcement personnel or persons able to prevent or lessen such harm.

5. For worker's compensation purposes when we release your PHI in order to comply with worker's compensation laws. If you do not want worker's compensation notified, alternate insurance or payment information must be supplied.

6. For appointment reminders and health-related benefits and services. We may use your demographic PHI to contact you as a reminder that you have an appointment or to recommend possible treatment options or alternatives that may be of interest to you.

C. YOU HAVE THE OPPORTUNITY TO AGREE TO OR OBJECT TO THE FOLLOWING:

Information shared with family, friends or others. We may release your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. Your choice to object may be made at any time.

D. YOUR PRIOR WRITTEN AUTHORIZATION IS REQUIRED FOR ANY USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION NOT INCLUDED ABOVE. We will ask for your written authorization before using or releasing any of your PHI. If you choose to sign an authorization to release your PHI, you may later cancel that authorization in writing. This will stop any future release of your PHI for the purposes you previously authorized.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

A. You Have the Right to Request Limits on How We Use and Release Your PHI. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit PHI that we are legally required or allowed to release.

B. You Have the Right to Choose How We Communicate PHI to You. All of our communications to you are considered confidential. You have the right to ask that we send information to you to an alternative address (for example, sending information to your work address rather than your home address) or by alternative means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested. Any additional expenses will be passed onto you for payment.

C. You Have the Right to See and Get Copies of Your PHI. You must make the request in writing. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, why we denied your request. You have the right to have the denial reviewed. We will choose another licensed healthcare professional to review your request and the denial. The person conducting the review will not be the person who denied your first request. You can request a summary or a copy of the entire medical record as long as you agree to the cost in advance. If your request to see the medical information is approved, we will arrange it.

D. You Have the Right to Get a List of Instances of When and to Whom We Have Disclosed Your PHI. This list will not include uses you have already authorized, or those for treatment payment or operations. This list will not include uses made for national security purposes, to corrections or law enforcement personnel, or made before April 15, 2003. We will respond within 60 days of receiving your request. The list we provide will include the last six years of activity unless you request a shorter time. The list will include dates when your PHI was released and why, with whom your PHI was released (including their address if known), and a description of the information released. The first list you request within a 12-month period will be free. You will be charged a reasonable fee for additional lists within that time frame. Please submit all requests for this information to Priority Radiology.

E. You Have the Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing or add the missing information.

F. You Have the Right to Request a Copy of This Privacy Notice.

HOW TO VOICE YOUR CONCERNS ABOUT OUR PRIVACYPRACTICES:

If you think that we may have violated your privacyrights, or you disagree with a decision we made about access to your PHI, you may file a complaint with our office. You also may send a written complaint to the Secretary of the Department of Health and Human Services at
200 Independence Avenue, SW
Washington, D.C. 20201
You will not be penalized for filing a complaint.

Priority Radiology

EFFECTIVE DATE OF THIS NOTICE

This notice is effective as of April 15, 2003