PET/CT IMAGING OF NORTH TEXAS
Comprehensive Imaging – Involved Patient Care

REQUEST AND CONSENT FOR RELEASE OF MEDICAL INFORMATION

1) I _____, do hereby authorize the release of all medical information to CCNT and PET/CT Imaging of North Texas to better manage my healthcare. This includes all pathology and/or cytology reports, laboratory reports, radiology reports and films, and any physician progress notes.

2) I hereby authorize the following person(s) to be involved with and receive information pertaining to my medical care:

NAME	RELATIONSHIP	PHONE NUMBER

_____ _____

PATIENT PRINTED NAME DATE

X_____

PATIENT/LEGAL PATIENT REP. SIGNATURE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our practice reserves the right to modify the privacy practices outlined in the notice.

3) I have reviewed this offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

_____ _____

PATIENT PRINTED NAME DATE

X_____ _____

PATIENT/LEGAL REP. SIGNATURE WITNESS SIGNATURE

2900 N I-35 STE 119 Denton TX 76201
940.387.8000 Phone: 940.387.8002 Fax
www.ccntx.com

PET/CT IMAGING OF NORTH TEXAS
Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our Patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our Patient Financial Counselor. We are dedicated to providing the best possible care and service to you and regard your understanding of your financial responsibilities as an essential element of your care and treatment. Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience, we accept payment by check, cash, debit card, Visa or Mastercard.

Your Insurance

• We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. This offices' policy is to collect this co-payment when you arrive for your appointment.

• Your assistance in securing timely payments of your claims may be required. If your health plan requires that you obtain prior authorization in the form of a REFERRAL from your primary care physician (PCP), or PRECERTIFICATION before procedures or treatment plans may be initiated, we ask that you inform our staff and assist us to assure these arrangements are made in advance.

• If you have insurance coverage with a plan for which we do not have prior agreement, we will prepare and send claims on your behalf. You should be aware however, that the Patients' share of the medical fees owed when using non-contracted physicians will usually be more than when using contracted physicians.

• Not all services are a covered benefit in all insurance plans. Some health plans select certain services that will not be covered. In the event that your health-plan determines a service to be "not covered" you will be responsible for the complete charge. Payment of the balance that is designated as the Patients' responsibility is due upon receipt of a statement from our office.

• We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

• Keep in touch: Do not assume your insurance carrier is "working on it". Contact them if you have not received a notice of payment within 30 to 45 days of your services. If payment is delayed by your health plan, you will be asked to contact them or your health benefits office to identify the issues. You will be held responsible for services not paid by your health plan.

Minor Patients

• For all services rendered to minor patients, we will look to the adult accompanying the patient, or the parent or guardian with custody, for payments.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF THE PRACTICE, AND I AGREE TO BE BOUND BY ITS' TERMS. I ALSO UNDERSTAND AND AGREE THAT THE PRACTICE MAY AMEND SUCH TERMS FROM TIME TO TIME.

_____

Printed Name of Patient

X_____ _____

Signature of Patient or Responsible Party (if minor Patient) Date

PET/CT IMAGING OF NORTH TEXAS

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CLINICAL INFORMED CONSENT FOR PET/CT IMAGING

PET/CT Imaging (Positron Emission Tomography/Computed Tomography, is a procedure in which a small amount of tracer is injected intravenously and images are taken of your body. The tracer is a radioactive isotope combined with glucose(sugar) that will show the pattern of glucose metabolism in your body. The Food and Drug Administration (FDA) has determined that this tracer is safe and has approved its use for this type of procedure. Prior to the injection of the tracer, the glucose level in your body will be measured using a small drop of your blood.

After the injection of the tracer, you will be asked to relax in a quiet, dimly lit room for approximately one hour while the tracer is absorbed by and distributed throughout your body. You will then be asked to go to the restroom to empty your bladder and remove all metal from your body. Images will then be acquired using a PET/CT scanner. The scan will consist of you lying on a table and being moved in and out of a round opening in the center of the machine. The scan will take approximately 30-60 minutes depending on the type of scan you are having. There is no alternate imaging method to PET/CT which will provide the same type of information.

The dose or amount of radiation exposure you will receive is very minimal. Half of the radioactivity will disappear in less than 2 hours, and the radioactivity will be completely out of your body in less than 24 hours. After the procedure you should drink extra fluids throughout the day to help eliminate the tracer from your body.

By your signature, you acknowledge that you understand the above information and that you are freely and knowingly giving your consent to have this PET/CT scan. You also attest that you have complied with the preparation instructions given to you and that you have not had anything at all by mouth with the possible exception of water within the last 6 hours.

_____ X_____

PATIENT PRINTED NAME PATIENT/LEGAL REP. SIGNATURE

_____ _____ _____

PATIENT/RESP.PARTY SIGNATURE WITNESS

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

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 your internal body parts. As part of your CT, a contrast agent may be injected into your vein in order to produce better images of the part of the body being examined.

People are exposed to radiation from natural sources all the time. All x-rays involve a small extra dose of radiation. At our facility, a dose of radiation used for CT examinations is carefully controlled to ensure the smallest possible amount is used that will still give a useful result.
The size of any increased risk depends on the age of the patient and the total amount of radiation received. The doctor(s) asking for this test will have weighed any risk against the benefit to be gained from the extra information the CT scan should provide.

I understand the procedure has the following **specific risks and limitations**:

- There is a very small risk associated with radiation exposure. This cannot be avoided.
- As a CT scan is usually avoided if a woman is pregnant, I must notify the staff if this may affect me.
- If I suffer from claustrophobia, I may find it difficult to remain still within the scanner and should warn the staff beforehand.
- *If I am allergic to iodine contrast or have ever had a reaction to iodine, I must notify technologist before any scan(s).

By your signature, you acknowledge that you understand the above information and that you are freely and knowingly giving your consent to have this CT scan. You also attest that you have complied with the preparation instructions given to you and that you have not had anything at all by mouth within the 4 hours prior to your scan.

_____ _____

PATIENT PRINTED NAME **DATE**

X_____ _____

PATIENT/LEGAL REP. SIGNATURE **WITNESS SIGNATURE**

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NEW PATIENT REGISTRATION

PATIENT NAME: _____ DATE: _____

SSN: _____ DATE OF BIRTH _____ AGE_____

MAILING ADDRESS: _____

CITY_____STATE_____ZIP_____

PHONE:(H)(C)(W) _____ ALT. PHONE#:(H)(C)(W)_____

MARITAL STATUS: SINGLE/MARRIED/ DIVORCED /WIDOWED/SEPERATED (*CIRCLE ONE*)

EMERGENCY CONTACT: _____

PHONE: _____RELATIONSHIP: _____

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN: _____

PRIMARY PHARMACY: _____PHONE: _____

NURSING HOME OR ASSISTED LIVING? ( )YES ( ) NO.

NAME OF CENTER: _____ PHONE NUMBER: _____

INSURANCE INFORMATION:

INSURED/RESP.PARTY NAME: _____ INSURED SSN: _____-_____-_____

INSURED DATE OF BIRTH: _____ RELATIONSHIP TO INSURED: SELF/SPOUSE/CHILD/OTHER

EMPLOYER: _____

The information above is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Denton Cancer Center/ Cancer Care of North Texas/ PET/CT Imaging of North Texas. I understand that I am financially responsible for any balance. I also authorize DCC to release any information necessary to receive payment from my insurance company.

X_____

PATIENT SIGNATURE/RESPONSIBLE PARTY DATE

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