GO IMAGING

# PATIENT INFORMATION / FINANCIAL RESPONSIBILITY

Name:_____ SSN: _____
Last First Middle Initial

Date of Birth:_____ Sex*: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ W ☐ D

Home Phone: (_____)_____ Daytime: (_____)_____ Cell: (_____)_____

Address: _____
Street Address (no PO boxes) City State Zip

_____
Mailing Address City State Zip

Email address: _____
(Your email will not be sold or given to any third parties. It will only be used internally.)

Employer: _____ Employment Status (circle): ☐ FT ☐ PT ☐ Retired ☐ Not Employed
Company Name

Emergency Contact: _____
Name Relationship Phone

How did you hear about us? ☐ Physician Referral ☐ Returning Patient ☐ Internet ☐ Word of Mouth ☐ Other

Were you injured? ☐ Y ☐ N **Is this injury work related?** ☐ **Y** ☐ **N** Are you filing a workers compensation claim? ☐ Y ☐ N

Do you reside in a Skilled Nursing Facility? ☐ Y ☐ N Name & Phone of SNF:_____

**INSURANCE-** Check all insurances you have: ☐ Medicare ☐ Medicaid ☐ PPO ☐ HMO ☐ LOP ☐ Work Comp ☐ Other

**Primary Insurance**:_____ Policy Holder:_____
Last First MI

SSN of Policy Holder:_____ Policy Holder's DOB: _____

Policy ID Number:_____ Group Number: _____

Patient's Relationship to Policy Holder (please check): ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder's Employer:_____ Work Phone: _____

***If you do not have a secondary insurance, please write "none."***

**Secondary Insurance**:_____ Policy Holder:_____
Last First MI

SSN of Policy Holder:_____ Policy Holder's DOB: _____

Policy ID Number:_____ Group Number: _____

Patient's Relationship to Policy Holder (please check): ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder's Employer:_____ Work Phone: _____

**Which method of payment will be used for today's visit?** ☐ Visa ☐ Mastercard ☐ AMEX ☐ Cash ☐ Check

***For Patients under 18, the Parent/Guardian accompanying minor must provide the information below and sign as the guarantor.***

Guarantor:_____ SSN: _____

DOB:_____ Phone:_____ Relationship to Patient: _____

Address: _____

I hereby certify that the above information is true and accurate to the best of my knowledge and JK Radiant, L.P. dba GO Imaging may rely on this information to provide these services. I assign and authorize that payment of these medical benefits be made directly to GO Imaging. I further authorize GO Imaging to release to my insurance carrier information pertaining to my examination and treatment. I understand that I am financially responsible for any charges not covered by my insurance carrier and a $25 fee per returned check cost of collection, if necessary. I understand if payment is not made by my insurance company and/or if I fail to comply with my payment arrangements, my credit report information may be obtained. By listing the information above, I am allowing GO Imaging to contact me via any of the methods I have provided.

**Signature of Responsible Party:** _____ **Date:** _____

# CT - PATIENT CONSENT

Patient Name:_____ Patient #: _____

You have the right to be informed about your condition and the recommended diagnostic procedure to be used, so that you may make the decision whether or not to undergo this procedure after knowing the risks and hazards involved. 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 you are pregnant, please inform the center personnel at once.

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

Potential risks: The following complications are possible any time an injection is given: there is potential for pain, bleeding, bruising, or swelling at the injection site. Additional allergic reactions in response to the contrast agent may include hives, shortness of breath, or difficulty in swallowing. There have been rare instances of death after the administration of the contrast agent. It is very important that you inform the technologist if you experience any of the conditions mentioned in this form.

NOTE TO PATIENTS: If you have 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, or if you are taking Glucophage, you MUST inform the technologist.

An alternative to this procedure may be an ultrasound, x-ray, MRI or no treatment. However, your physician believes the CT to be the best diagnostic test for you, considering your symptoms and condition. 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 (WE) 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) HAVE SUFFICIENT INFORMATION TO GIVE THIS INFORMED CONSENT.

_____ Date: _____ Time:_____
(Patient / Parent / Legal Guardian Signature)

_____ Date: _____ Time:_____
(Witness Signature)

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PATIENT/INTERNAL
CT

# CT - TECH SHEET

Patient Name:_____ Date:_____
Last Name First Name Middle Initial

D.O.B.: _____ Age: _____ Sex: ☐ M ☐ F Weight: _____ Ht: _____

Were you injured? ☐ Yes ☐ No If yes, when & how?_____

**Describe your symptoms** (☐ Aching ☐ Burning ☐ Pins and Needles ☐ Radiating ☐ Stabbing ☐ Weakness etc.):

_____

Have you had a previous exam related to this body part? ☐ Yes ☐ No
**If yes**, when, where and results:_____

Do you or have you smoked? ☐ Yes☐ No *If yes*, how much and for how long?_____

List all previous surgeries: _____

**ANY PERSONAL HISTORY OF:**

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| | | Asthma | | | Dizziness |
| | | Allergic Respiratory Disease | | | Heart Disease |
| | | Diabetes | | | Stroke |
| | | Kidney Problems | | | Liver Disease |
| | | Cancer | | | Seizure Disorder |
| | | Multiple Myeloma | | | Bladder Disease |
| | | Prostate Problems | | | Headaches |
| | | Are you breast feeding at this time? | | | Hypertension (High Blood Pressure) |
| | | Renal Failure | | | Under care of Internal Med. Specialist/ Nephrologist |

List other medical problems: _____

In the past 24 hours have you had an IV Contrast injection? ☐ Yes ☐ No

**If yes**, explain:_____

Are you allergic to Iodine (IV Contrast)? ☐ Yes ☐ No

**If yes**, what is the reaction? _____
***(If reaction is Hives or Rash, pre-meds will be needed.)***
**If Pre-meds** were needed, did you take your Pre-meds? ☐ Yes ☐ No

Are you taking glucophage? ☐ Yes ☐ No

List all medications presently taking: _____

List all food and drug allergies: _____

Do you or have you had any allergic reactions?: _____

When did you last eat anything?_____

When did you last drink anything?_____

_____ _____ _____
Patient Name Patient Signature (***If patient is under 18 years of age, guardian must sign***) Date

***FEMALE PATIENTS MUST FILL OUT THE BACK SIDE OF THIS FORM***

*FEMALE PATIENTS:*

Any possibility of pregnancy? ☐ Yes ☐ No Last Menstrual Period: _____

Are you sexually active? ☐ Yes ☐ No

Do you ever have unprotected sex? ☐ Yes ☐ No

Are you using birth control? ☐ Yes ☐ No

_____ _____

Female Patient Signature ***(If patient is under 18 years of age, guardian must sign)*** Date

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## Authorization for Use or Disclosure of Information

I, _____, hereby authorize ***JK Radiant, L.P. dba GO Imaging*** (hereafter ***GO Imaging***) to: (*Please check one or both of the following:)*

_____use and disclose the following protected health information to any physician that can reasonably identify me by name, date of birth and social security number and, and/or

_____use and disclose the following protected health information to:

*(Please indicate below to whom we may release information. Please include the names of family members and/or friends.)*

_____

(*Please check off what type of information you would allow us to release*.)

_____all medical records _____all billing records

This protected health information is being used or disclosed for the following purpose: To diagnose and/or treat the patient and/or: [List specific purposes here:]_____.

This authorization shall be in force and effect **indefinitely**; I understand that an expiration date may be applied at the time of service and/or that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **notices@go-imaging.com.** I understand that a revocation is not effective to the extent that ***GO Imaging*** has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. ***GO Imaging*** will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

[The use or disclosure requested under this authorization will result in direct or indirect remuneration to ***GO Imaging*** from a third party.] [if applicable.]

_____ _____

Signature of Patient or Personal Representative | Name of Patient or Personal Representative

_____ _____

Date | Description of Personal Representative's Authority

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## Consent for Purposes of Testing, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by ***JK Radiant, L.P. dba GO Imaging*** (hereafter ***GO Imaging***) for the purpose of providing services to me, obtaining payment for my health care bills or to conduct health care operations of ***GO Imaging***. I understand that service provided to me by ***GO Imaging*** may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out services, payment or healthcare operations of the facility. ***GO Imaging*** is not required to agree to the restrictions that I may request. However, if ***GO Imaging*** agrees to a restriction that I request, the restriction is binding on ***GO Imaging***. I have the right to revoke this consent, in writing, at any time, except to the extent that ***GO Imaging*** has taken action in reliance on this consent.

I understand I have a right to review ***GO Imaging*** Notice of Privacy Practices prior to signing this document and that it is available upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my test, the payment of my bills or in the performance of health care operations. ***GO Imaging*** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail.

As a courtesy, our facility will file your claim to your insurance company. However, since there is no guarantee of payment by an insurance company, you will be responsible for payment for services received in our office should the insurance not pay plus the cost of collection, if needed. Should collection proceeding or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that ***GO Imaging*** has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection.

_____ _____

Signature of Patient or Personal Representative | Name of Patient or Personal Representative

_____ _____

Date | Description of Personal Representative's Authority