SACRAMENTO IMAGING

2233 WATT AVE.,SUIT 103, SACRAMENTO CA 95825 _____
1995 ZINFANDALE DR. SUITE 103 RANCHO CORDOVA CA 95670____

Patient Information and Consent Form

Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insured, your information on this form may be shared with your insured. Your health information will be kept confidential by your insured.

PATIENT INFORMATION: Today's date: _____

Last Name:_____ First Name:_____Middle Initial: _____

Examination requested:_____ Referring MD: _____

Date of Birth: _____ / _____ / _____ Sex:Female__ Male__SS #:_____

Mailing Address:_____
(Street or P O Box) City State Zip Code

Home Phone: (_____) _____ - _____ Work Phone (_____) _____ - _____

Mobile Phone (_____) _____ - _____ Email Address _____

If the patient is a minor (under 18 years of age) , please complete the following:

Responsible Party: _____ Relationship: _____

Mailing Address, if different from above: _____

Home Telephone: (_____) _____ - _____ Work Telephone: (_____) _____ - _____

INSURANCE INFORMATION: (A photo ID and ALL insurance cards are required to be presented to Registration for each visit; they will be returned to you.)

Primary Insurance:

Policy Holder: _____ _____ _____ - ____ - _____ ____/____/_____
Last name First Name MI Social Security # Date of Birth

Secondary Insurance:

Policy Holder: _____ _____ _____ - ____ - _____ ____/____/_____
Last name First Name MI Social Security # Date of Birth

Consent & Acknowledgment

I authorize United Care Foundation (dba) Sacramento Imaging to release any medical or other information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original. If assignment is accepted, I request payment of insurance benefits be made directly to Sacramento Imaging. I am responsible for the deductible, co-payment, and non- covered service (as determined by my insurer.) I understand that any deductible or coinsurance payments made on this exam date are estimates based on information Sacramento Imaging received from my insurance company prior to submission of the claim for this exam. Once a claim is submitted to my insurance carrier for the exam, I understand that I may be responsible for additional amounts in accordance with my individual insurance plan and acknowledge that Sacramento Imaging will bill me for the balance remaining. I authorize release of information, films, and copies pertinent to my medical history and for follow-up of any suspicious finding. This consent authorizes Sacramento Imaging to release to my insurance company, referring physician and other physicians participating in my care my medical record, including images and reports. If there are physicians that you would like to designate as NOT ALLOWED to access your medical record, including images and reports, please list them below.

Yourself, or others having your written permission, will be required to present photo I.D. when picking up Medical Records.

Sacramento Imaging has permission to call and leave a message regarding any medical history, results, or my patient information on the voice mail or answering machine for the numbers listed above.

As a patient of Sacramento Imaging, I acknowledge that I had the opportunity to review Sacramento Imaging Notice of Privacy Practices, as required by HIPAA. I understand I may request a paper copy of this policy to keep.

Patient's Signature: _____ ***Date:*** _____

**If patient is a minor, responsible party please sign*

If in the future you believe you may need another individual (family or other) to pick up your medical images and/or reports, please list the person's name, DOB and relationship below.

Name	**Relationship**	**Date of Birth**

Patient's Signature: _____ ***Date:*** _____

**If patient is a minor, responsible party please sign*

CLINICAL INFORMATION GENERAL/CHEST X-RAY

ACCT # LHI___|QTC___|VES___|Other_____ Tech's Init./Exam Date _____/_____

Patient's Name _____ Referring Physician _____

Date of Birth_____ Age_____ Next Appointment with Referring Physician _____

TYPE OF EXAM ☐ PA Chest ☐ Complete Chest ☐ Abdominal, Flat ☐ Abdomen, Flat and Upright
☐ Skull ☐ Sinus ☐ Ribs ☐ C-Spine ☐ L-S Spine ☐ T-Spine
☐ Extremity (area) _____
☐ Other _____

Why are you having this examination (medical problem) including symptoms? _____

_____

_____

_____

List other imaging studies you have had/will have regarding this problem and where they were performed (if applicable):

☐ CT _____ ☐ X-ray _____ ☐ Ultrasound_____
☐ MRI _____ ☐ Nuclear Medicine/PET _____ ☐ Other_____

What were the results? _____

Did you bring a copy of the results and films?_____

History and dates of prior surgeries of this area: _____

_____

Do you have a personal or family history of cancer? ☐ Yes ☐ No

If yes, please explain. _____

CHILDBEARING WOMEN ONLY Date of last menstrual period_____

Are you possibly pregnant? ☐ Yes ☐ No Patient's
(If yes, notify technologist immediately) Signature_____ Date_____

FOR CHEST X-RAY PATIENTS ONLY

Please check any of the following symptoms you may be experiencing:

☐ Cough ☐ Wheezing ☐ Chest Pain ☐ Shortness of Breath ☐ No Symptoms
☐ Fever ☐ Recent Foreign Travel ☐ Other _____

Comments: _____

_____

Have you had a previous chest x-ray? ☐ Yes ☐ No

If yes, when?_____ Where? _____

Please circle appropriate answer: Smoker Ex-Smoker Non-Smoker

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YOUR INSURANCE COMPANY MAY OR MAY NOT REIMBURSE FOR ROUTINE X-RAYS.
I understand that I am responsible for full payment if my insurance company does not pay.

_____ _____

Patient's Signature Date