

Include face sheet STAT circle & Call if Exam is STAT!

DATE TO BE DONE	PATIENT: LAST	FIRST	MI	ROOM#	M	F	DATE OF BIRTH

___ 2233 Watt Ave, Suite 120, Sacramento, CA, 95825
 ___ 1995 Zinfandel Drive, Suite 103, Rancho Cordova, CA, 95670

PATIENT'S SOCIAL SECURITY NUMBER

ORDERING PHYSICIAN

_____ PHONE # _____

_____ FAX # _____

This patient would find it physically and / or psychologically taxing because of advanced age /or physical limitations to receive an X-RAY outside this location. This test is medically necessary for the diagnosis and treatment of this patient.

RESPONSIBLE PARTY

NAME _____

STREET _____

CITY _____ STATE _____ ZIP _____

PHONE _____

PLEASE INCLUDE COPIES OF THE INSURANCE CARDS

MEDICARE # _____

MEDICAID # _____ STATE _____

CO / OTHER INSURANCE _____

POLICY # _____

AGE 55 AND UNDER: I AM/AM NOT PREGNANT. IF YES, SHEILDING WAS USED WHEN POSSIBLE.
PT. SIGNATURE: _____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND/OR ANY INSURANCE BENEFITS BE MADE DIRECTLY TO SACRAMENTO IMAGING AND/OR THE INTERPRETING PHYSICIAN FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN OR SUPPLIER. 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 PAYABLE FOR RELATED SERVICES. I also acknowledge that all services may not be covered in full by my insurance and I will pay in full any balance due to Sacramento Imaging.

PATIENT'S SIGNATURE

MANAGED CARE PHYSICIAN

<h3 style="text-align: center;">ULTRASOUND</h3> <p>76536 Thyroid/Neck</p> <p>76642 Breast Ultrasound Limited 76700 Abdominal</p> <p>76770 Retroperitoneal</p> <p>76880 U/S Ext Non Vascular</p> <p>76805 OB U/S</p> <p>76856 Pelvic Ultrasound</p> <p>76870/93975 Scrotum/Testicle</p> <p>93880 Carotid Doppler</p> <p>93922 Ankle/Brachial Index</p> <p>93923 Segmental Pressures Low Ext</p> <p>93925 Arterial Doppler Bilat Low Ext</p> <p>93926 Arterial Doppler Unilateral Low Ext</p> <p>93930 Arterial Doppler Bilat Upp Ext</p> <p>93931 Arterial Doppler Unilateral Upp Ext</p> <p>93970 Venous Doppler Bilat</p> <p>93971 Venous Doppler Unilateral</p> <p><input type="checkbox"/> OBS (Below 16 Weeks)</p> <p><input type="checkbox"/> OBS (Above 16 Weeks)</p> <p><input type="checkbox"/> OBS (High-risk/problem)</p>	<h3 style="text-align: center;">X-RAY</h3> <p>Gastro-Urological</p> <p>74000 Abdomen/KUB (1 view)</p> <p>74020 Abdomen (2 view)</p> <p>Q9963 Gastrografin</p> <p>Head & Neck</p> <p>70260 Skull (4 view)</p> <p>70220 Sinuses (3 view)</p> <p>70110 Mandible (4 view)</p> <p>70150 Facial Bones (3 view)</p> <p>70160 Nasal Bones (3 view)</p> <p>70200 Orbits (4 view)</p> <p>70140 Maxilla (2 view)</p> <p>70360 Soft Tissue Neck (2)</p> <p>Chest</p> <p>71010 Chest (1 view) 71020 Chest (2 view) 71101 Ribs Unilat w/CXR 71111 Ribs Bilat w/CXR 71120 Sternum (2 view)</p>	<h3 style="text-align: center;">CARDIOLOGY</h3> <p>93005 Electrocardiogram EKG</p> <p>93306 Echocardiogram (2D)</p> <p>SLEEP TESTS</p> <p>95806 Sleep Study W/o Sleep Time</p> <p>G0399 Home Sleep Test With Type 3 Portable Monitor</p> <p>95800 Sleep Study</p> <p>PULMONARY FUNCTION TEST</p> <p>94070 Bronchospasm Provocation Test</p> <p>94010 Spirometry</p> <p>94060 Spirometry Pre and Post Bronchodilator</p> <p>94727 Gas Dilution For Lung Volume</p> <p>94729 CO2/Membrane Diffuse Capacity</p> <p>94375 Flow Volume Loops</p> <p>94200 Maximum Breathing Capacity</p> <p>94618 Pulmonary Stress Testing</p> <p>94726 Total Lung Capacity - Lung Volume/Plethysmography</p> <p>94640 Inhalation Treatment</p> <p>94760 Pulse Oxymetry</p>
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PLEASE NOTE REASON FOR SERVICES :

NOTES: Symptoms / Brief History/Diagnoses:

Insurance: _____ Self-paid Visa M/C Cash

R0070 Transportation fee: \$ _____ Q0092 Setup fee: \$ _____ X-ray fee: \$ _____ Ultrasound fee: \$ _____ PFT fee: \$ _____ Total charges: \$ _____

DATE TAKEN	TECH	# OF PATIENTS THIS VISIT	# OF VIEWS	CHART #	RADIOLOGIST	R0070-Transport (1 pt)	R0075-Transport (>1 pt) 99058-STAT exam (only for Mobile services)	Q0092-setup
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