Metro Region PET Center
Phone: (703) 698-5593 • Fax: (703) 698-5171

Woodburn Nuclear Medicine
Phone: (703) 698-0666 • Fax (703) 573-6120

Patient's Name: _____ Date of birth: _____ Age: ___ Sex: ___

Date: _____ Are you a new patient? Yes / No Height: _____ Weight: _____ Soc Sec #: _____

Emergency Contact: _____ Relationship: _____ Telephone Number: _____

Are you an inpatient in a hospital or nursing facility? Yes / No <u>IF YES, PLEASE ALERT OUR STAFF!</u>
****

Are you pregnant? Yes / No Date of your LMP: _____ Are you breastfeeding? Yes / No

Briefly describe in the space below why you were referred you for a PET/CT or a CT scan:

- Has it been at least 6 hours since you've consumed any food or drink (other than water)? Yes / No
- Over the past 6 months have you experienced any weight loss? Yes / No
  - If yes, approximately how much? _____lbs.
- Do you currently have any type of ***infection***? Yes / No
  - If yes, please provide details: _____
- Are you currently on, or have you recently completed, ***intravenous chemotherapy***? Yes / No
  - If yes, please list medication(s):_____
  - Date the last cycle ended: _____
- Are you on ***oral chemotherapy*** or a ***hormonal therapy*** regimen? Yes / No
  - If yes please list: _____
  - Date of the last dose: _____
- Have you received any ***unconventional therapies*** (e.g.: immunotherapy, experimental protocol therapy, etc.)? Yes / No
  - If yes, please provide details: _____
  - Date of the last treatment: _____
- Have you received ***radiation*** therapy? Yes / No
  - If yes, indicate the anatomical part of your body: _____
  - Date of last therapy: _____

Patient's Name: _____

- Is more radiation therapy planned? Yes / No

- Please list all ***recent surgical procedures*** below:

1)_____date: _____ 3)_____date: _____

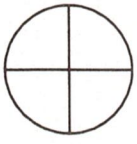
2)_____date: _____ 4)_____date: _____

- List all medications you are currently taking: _____

_____

- ***Breast Cancer Patients***: Please place a dot in the diagram below to indicate the location of your original tumor.

Right Breast



Left Breast

_____

PLEASE COMPLETE BELOW IF THIS IS YOUR FIRST VISIT TO OUR FACILITY

- List all major medical problems: _____

_____

- Are you now a smoker? Yes / No
  - If yes, for how long? _____ If you quit, how long ago? _____

- Have you had a biopsy? Yes / No
  - If yes, give date and results. _____

- Have you been diagnosed with cancer? Yes / No
  - If yes, when was the cancer diagnosed? _____
  - Specify the type of cancer. _____
  - How did your physician diagnose the cancer? _____

****

FRONT DESK PERSONNEL ONLY

- Did the patient bring outside films or discs? Yes / No
  - If yes, provide the date: _____

- Have previous reports been provided? Yes / No
  - If yes, provide the date: _____

CCs:

****

Patient's Name: _____ Date of Service: _____

The **Centers for Medicare and Medicaid Services (CMS)**, the Federal Agency which administers Medicare and Medicaid, now requires that we collect the following information from all patients. This will be kept confidentially in your Electronic Medical Record.

More information regarding this requirement can be found at www.CMS.gov. We apologize for the inconvenience and we appreciate your understanding.

Race (please check one)

- o White
- o Black/African American
- o American Indian/Alaskan Native
- o Native Hawaiian/Pacific Islander
- o Asian

Ethnicity (please check one)

- o Hispanic/Latino
- o Non-Hispanic/Non-Latino

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Notice of Privacy Practices and Patient Consent
For Use and Disclosure of Protected Health Information

Patient's Name: _____

Date of Service: _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain *Patient Rights* regarding my protected health information.

I understand that Woodburn Nuclear Medicine / Metro Region PET Center may use or disclose my protected health information for treatment, payment and/or health care operations - which means for providing health care to me, the patient, handling billing and payment and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Woodburn Nuclear Medicine / Metro Region PET Center has a detailed document called '***Notice of Privacy Practices***'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice' before* signing this agreement. If I ask, Woodburn Nuclear Medicine / Metro Region PET Center will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review a copy of the *Notice of Privacy Practices.* My signature means that I agree to allow Woodburn Nuclear Medicine / Metro Region PET Center to use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Woodburn Nuclear Medicine / Metro Region PET Center has already taken action relying on this consent.

_____ _____
Signature Date

_____ _____
Relationship to patient (if signed by another party) Date

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice"*, at any time by contacting Woodburn Nuclear Medicine / Metro Region PET Center (refer to contact information above).

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Assignment of Insurance Benefits

Metro Region PET Center/Woodburn Nuclear Medicine is pleased to extend the courtesy of billing your insurance carrier for you for today's services. In doing so, we will make every effort to collect the fee for today's visit from your carrier.

If you are having a Positron Emission Tomography (PET) scan, please note that some insurance companies do not reimburse for PET scans for certain diagnoses even if they have been properly authorized or verified in advance.

I, _____, assign the benefits of my medical insurance coverage from my insurance carrier, _____, policy number _____, to Metro Region PET Center/Woodburn Nuclear Medicine, for charges pertaining to medical treatment extended to me on _____ (date of service).

I grant Metro Region PET Center/Woodburn Nuclear Medicine the right to pursue any appeals with my insurance carrier named above to secure full policy benefits. If my insurance company requests my medical records, I authorize Metro Region PET Center/Woodburn Nuclear Medicine to release such information to help secure payment.

I understand that I will be responsible for the above-mentioned charges if my insurance coverage has lapsed, was not in effect, I was ineligible for coverage on this date of service or if my insurance company denies payment. I further understand that any portion of today's charges not paid by my insurance company will be my responsibility and must be paid upon receipt of a statement. I may have the option to set up a mutually agreeable payment plan if requested.

I understand that should it become necessary to turn my account over to an outside collection agency, I will be responsible for collection costs, attorney fees, litigation expenses and court fees, if applicable.

_____ _____

Signature of Patient or Guardian **Date**

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Patients over 65 Years of Age

Please note that it is the patient's responsibility to provide Metro Region PET/Woodburn Nuclear Medicine Center with the necessary information to properly file your claim.

If you have Medicare coverage in addition to any other commercial insurance, you must provide us with complete membership information for both plans.

Unfortunately, all denied claims due to incomplete insurance information will become your financial responsibility.

I, _____, understand the policy stated above and agree to abide by its terms.

Patient's signature: _____ Date:_____

****

I, _____, DO / DO NOT have Medicare Part B.
(PLEASE CIRCLE ONE)

Patient's signature: _____ Date:_____

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Authorization to Receive and to Disclose Protected Health Information

Patient's Name: _____ Patient's Address: _____

_____

_____

Date of Birth: _____

I authorize the disclosure of my medical records and other documentation that pertains to my healthcare, treatment, insurance billing and/or benefit eligibility **to** Metro Region PET Center/Woodburn Nuclear Medicine.

I also authorize Metro Region PET Center/Woodburn Nuclear Medicine to disclose my medical records for the purposes of monitoring my care and treatment, insurance billing and/or benefit eligibility. I understand that it is my responsibility to provide any restrictions regarding release of my protected health information to Metro Region PET Center/Woodburn Nuclear Medicine. This information will become part of my medical record.

I understand that this information will be forwarded by either facsimile transmission, email, regular mail or courier and that Metro Region PET Center/Woodburn Nuclear Medicine will take every precaution to protect my information while it is in their custody. However, I release Metro Region PET Center/Woodburn Nuclear Medicine from any liability for breach of confidentiality or misdirection of these records once they leave the facility's control.

I understand these records may contain sensitive information including documentation pertaining to HIV testing, medical reports and administrative data.

I understand that I have the right to revoke this authorization at any time in writing. This revocation will not pertain to information that has already been released in response to this authorization. I further understand that this revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim.

This facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Signature of Patient or Guardian **Date**

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Pregnancy & Breast-Feeding Verification Statement

Female patients under the age of 55 years are requested to complete this form.

I, _____, understand that some nuclear medicine tests require that I receive a radioactive tracer that would not routinely be administered to pregnant, potentially pregnant or breast-feeding women.

- **With my signature below, I affirm that even though it has been more than 10 days since the onset of my last menstrual cycle there is no chance that I am pregnant.**

  Date of last menstrual cycle: _____

- **I further affirm that I am not breast-feeding.**

Patient's signature: _____ Date: _____

Appointment Date: _____

Technologist's signature: _____ Date: _____