

Prestonwood Imaging Center

6957 West Plano Parkway, Suite 1100
Plano, Texas 75093
Office 972.395.7533 Fax 972.395.7536

CT Patient Information

Name: _____ Date: _____

Address/City/State/Zip: _____

DOB: _____ SSN: _____ Height / Weight _____

Sex: Male / Female Referring Physician _____

Have you had any previous studies that pertain to your problem, within the last 12 months?

_____ *MRI* When/Where? _____
_____ *CT* When/Where? _____
_____ *X-RAYS* When/Where? _____

Please list any surgeries that you have had in your lifetime:

Please list all medications that you are currently taking: _____

Why are you here today for this exam? _____

I authorize the release, by Prestonwood Imaging Center, for any medical information and/or films necessary to process claims for payment; the release to other physicians or medical facilities as designated by me and/or to obtain previous reports and/or films to aid in our radiologist's interpretation of results.

Patient's Signature: _____ Date: _____

I authorize direct payment of all medical benefits to Prestonwood Imaging Center.

Patient's Signature: _____ Date: _____

TECHNOLOGIST INITIAL: _____

Prestonwood Imaging Center
Consent for Contrast Material Injection

Name: _____

DOB: _____

Your physician has scheduled you for an examination that requires the injection of a contrast agent into your bloodstream. This contrast assists the Radiologist to interpret the exam.

The contrast material is injected through a small needle placed into a vein. Normally, contrast is considered quite safe. However, any injection carries a slight risk of harm including: infection, injury to a nerve, artery, or vein, or reaction to the contrast being injected. Occasionally, a patient will have a mild reaction to the contrast and develop sneezing or hives. The incidence of a serious reaction (anaphylactic shock or impaired renal function) is only about 4 in 10,000. In extremely rare cases, death has occurred (currently reported at 1 in 130,000 or 0.00076 %). Certain patients are at a higher risk for a reaction. In order to help us determine your risk factor, please answer the following questions to the best of your knowledge.

Have you ever had a previous imaging study which required the use of an intravenous contrast material (x-ray dye, IVP, iodine)? YES / NO

Have you ever had a previous reaction to contrast material? YES / NO
If so, please briefly describe: _____

Do you have any kind of allergies including asthma or hay fever? YES / NO
If so, what are you allergic to? Please list below:

Food: _____

Medications: _____

Environmental: _____

Do you have known kidney disease? YES / NO

Do you have high blood pressure? YES / NO

Do you have heart disease? YES / NO

Do you have multiple Myeloma? YES / NO

Do you have Sickle Cell Anemia? YES / NO

Do you have Diabetes? YES / NO

If yes, what diabetic medication do you take? _____

I have answered the above questions to the best of my ability and give my consent for the use of intravenous iodinated (containing iodine) contrast material.

Patient's Signature: _____ Date: _____

TECHNOLOGIST INITIAL: _____

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Clinic: 519

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ Date of Birth: _____ Date of Visit: _____

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree that it is my responsibility and not the responsibility of the physician or clinic to know if my insurance will pay for my medical service or visit, preventative exam or physical, lab testing, x-ray, EKG, or any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or a higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree that it is my responsibility to know if my PCP (primary care physician) choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Patient's Signature: _____ Date: _____
(please sign here-Patient or Responsible Party)

Responsible Party Name: _____
(please print name of Responsible Party if different from Patient)

Attention: Prestonwood Patients!!!!

24-48 Hours after your procedure,
your primary care Doctor will
receive a report. In order to get
your results, you must consult your
Doctor. Should you choose to see a
Specialist or get a second opinion,
you are responsible for calling us 48
hours in advance in order to request

your films and report. In order to
provide the best service possible to
you and your Doctor, we need your
cooperation. Please let us know
how we may assist you.

THANK YOU

Patient Signature _____

Date _____

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X-RAY, CT & MRI Pregnancy Questionnaire
for Females Age 10-55 Years

Name: _____ Date: _____

DOB: _____ Age: _____

To your knowledge, are you pregnant? YES / NO

If so, how far along are you? _____
(Also, IF YOU ARE PREGNANT, please notify the technologist and the front desk
BEFORE proceeding with your exam!)

If you are NOT pregnant, when was the date of your last menstrual cycle? _____

Are you presently on some method of birth control? YES / NO

If so, please specify the method: _____

Have you had a hysterectomy? YES / NO

Have you had a tubal ligation? YES / NO

Are you currently a breast feeding mother? YES / NO

If so, we ask that you do not breastfeed for 48 hours following the administration of
intravenous-iodinated (containing iodine) contrast material.

I have answered the above questions to the best of my ability. I have been informed of the potential risks involved if I am pregnant from the CT and/or MRI technologists. By signing this authorization form, I am giving my consent to proceed with the CT and/or MRI scan that my referring physician has ordered for me today.

Patient's Signature: _____ Date: _____

TECHNOLOGIST INITIAL _____