CT
I.V. CONTRAST
PATIENT HISTORY & CONSENT

ASPIRE Hospital

Patient Name: _____ DOB: _____

Current symptoms/date began: _____

Have you had X-ray contrast (dye) injected before? Yes ☐ No ☐ Did you have a reaction? Yes ☐ No ☐

Are you allergic to Iodine? Yes ☐ No ☐ If **YES**, have you been pre-medicated for this scan? Yes ☐ No ☐

Are you diabetic ? Yes ☐ No ☐ If **YES,** what diabetic medications do you take? _____

Do you have a history of Renal (Kidney) Disease? Yes ☐ No ☐ Are you currently on Dialysis? Yes ☐ No ☐

FEMALES: Is there a possibility you might be pregnant? Yes ☐ No ☐ Last Menstrual Cycle: _____

Yes ☐ No ☐ History of heart disease, angina or heart attack? Yes ☐ No ☐ History of pulmonary hypertension (high blood pressure)?

Yes ☐ No ☐ History of asthma or other breathing disorders? Yes ☐ No ☐ History of hay fever?

Yes ☐ No ☐ Allergies to food or medications? _____

Yes ☐ No ☐ Do you have or ever had cancer? Type: _____

Previous exams of the area to be scanned today? **X-RAY** ☐ **CT** ☐ **MRI** ☐ **US** ☐ Facility/Date: _____

Your doctor has requested a radiology examination that requires an intravenous contrast injection. The contrast material used is an iodine containing solution that circulates through the blood stream. This allows the blood vessels of body to be better visualized. The contrast is then collected by the kidneys, and is urinated out of your body within a few hours. Most patients experience no unusual effects from this injection. Patients may experience a warm sensation throughout the body, a metallic taste, urgency of urination, nausea or vomiting. These are considered normal side effects and are not experienced by everyone, and are not considered allergic reactions. A small number of patients may have a mild allergic-type reaction, such as facial swelling, sneezing, hives or difficulty breathing or swallowing. In most circumstances, the risk of a reaction is extremely small. The risk is somewhat greater in asthmatics and patients with multiple allergies. Serious or life threatening contrast reactions are extremely rare. Naturally, medications are on hand to treat these conditions, should they occur and your doctor will be notified. Your physician is aware of these possible complications but has determined that the additional diagnostic information provided by the contrast outweighs the minimal risks of this procedure. ** To minimize the chance of nausea and vomiting, please DO NOT eat anything for 3-4 hours prior to your exam, except the Oral Contrast drink (if applicable).

I attest that the information provided is correct to the best of my knowledge. I have read and understand the above statement regarding non-ionic I.V. contrast and give my consent to use such contrast for my procedure. All of my questions concerning contrast and possible reactions have been answered to my satisfaction.

_____ _____ _____

Patient Signature **Today's Date** **Tech Initials**

TECHNOLOGIST USE ONLY

Contrast Type: _____ **Amt. Injected:** _____ **Exp. Date:** _____

Creatinine: _____ **GFR:** _____ **Date Drawn:** _____

Oral Contrast Type: _____ **Total Amt.:** _____

EXAM: _____ **DIAGNOSIS:** _____ **MR#:** _____

NOTES: _____

_____

CT

NON-CONTRAST

PATIENT HISTORY & CONSENT

PATIENT NAME: _____DOB: _____

Current symptoms(If Any) & Date symptoms began: _____

_____

FEMALES: Is there a possibility you might be pregnant? Yes ☐ No ☐ Last Menstrual Cycle: _____

Have you had previous exams of the area to be scanned today? **X-RAY** ☐ **CT** ☐ **MRI** ☐ **US** ☐

Performed at which Facility and Approximate Date: _____

Your doctor has asked for a special x-ray examination called a CT scan or Computerized Tomography. During this test, a thin X- ray beam is rotated around the area of the body the doctor wants more information about. The scan itself is painless, but you will have to remain completely still on the examination table while the scan is being done.

People are exposed to radiation from natural sources all the time. All x-rays involve a small extra dose of radiation. The dose of radiation used for CT examinations is carefully controlled to ensure the smallest possible amount is used that will still give a useful result. However, all radiation exposure is linked with a slightly higher risk of developing cancer. The size of any increased risk depends on the age of the patient and the total amount of radiation received. The risk of any one scan is very small indeed, but increases if many scans are needed. The doctor(s) asking for this test will have weighed any risk against the benefit to be gained from the extra information the CT scan should provide.

I understand the procedure has the following specific risks and limitations:

There is a very small risk associated with radiation exposure. This cannot be avoided. A CT scan is usually avoided if a woman is pregnant, I should tell the staff if this may be of concern. If I suffer from claustrophobia, I may find it difficult to remain still within the scanner and should warn the staff beforehand.

I attest that the information provided is correct to the best of my knowledge. I have read and understand the possible risks and complications specific to my personal circumstances, and they have been considered in deciding to have this procedure performed. All of my questions regarding this exam have been answered to my satisfaction.

_____ _____ _____

Patient Signature **Today's Date** **Tech Initials**

TECHNOLOGIST USE ONLY

EXAM: _____**DIAGNOSIS:** _____**MR#:** _____

NOTES:_____

_____

Conditions and Authorization for Medical Treatment – Outpatient

1. CONSENT FOR MEDICAL PROCEDURES AND TREATMENT: Permission is hereby granted to Aspire Hospital Outpatient Services for such medical procedures, including the taking of photographs and/or videos for treatment only, as may be deemed necessary by my physician and/or his or her designee. I further consent to treatment by authorized employees or agents who are assigned to my care. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the results of treatments, examinations, emergency services, or hospital care.
2. CONSENT FOR BLOOD BORNE INFECTIOUS DISEASE TESTING: I give my consent to have testing for blood-borne infectious disease, including but not limited to Hepatitis, Acquired Immune Deficiency Syndrome (AIDS), and Human Immunodeficiency Virus (HIV). This test is required in the following situation(s): (1) if a health care worker is accidentally exposed to a patient's blood or bodily fluids, such as through a needle stick, or (2) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or bodily fluids. This disclosure is to inform you that you will be tested if any of these situations occur during your visit.
3. NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been given the opportunity to review the Hospital's Notice of Privacy Practices. I understand that if I have question or complaint, I may contact the hospital's HIPAA Privacy Officer.
4. PATIENT RIGHTS AND RESPONSIBILITIES: I acknowledge that I have received a copy of the Patient Rights and Responsibilities and have had an opportunity to ask questions.
5. ASSIGNMENT OF BENEFITS: This assignment of benefits allows the Hospital and/or hospital based physicians to be paid directly by my health insurance carrier or other health benefit plan for the services the Hospital and or hospital based physicians proved to me, my minor child, or other person entitled to health care benefits for this visit. In consideration of the services to be rendered, the undersigned (as parent, guardian, spouse, guarantor, and agent or as the patient) individually promises to pay the patient's account at the rates that are usual, customary, and reasonable for services rendered. Thus the entire account balance including those charges filed with the insurance company, remains the patient's responsibility; I understand that there are providers that will bill me separately and that I am financially responsible to each provider for allowed charges not covered by this assignment.
6. MEDICARE PATIENT CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII and Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf.
7. RELEASE FROM RESPONSIBILITY FOR VALUABLES: It is understood and agreed that the hospital does not maintain a safe for the safekeeping of money and valuables and that the hospital shall not be liable for loss or damage to any money, personal valuables, or personal property.
8. PHYSICICAN OWNED HOSPITAL: Aspire Hospital, LLC believes that you are entitled to make informed decisions regarding your medical care. To assist you in making those decisions, the Hospital herby notifies you that it meets the federal definition of physician owned hospital pursuant to 42 C.F.R 489.3. As per the code of Federal Regulations you are hereby informed that a list of the Hospital's physician owners and investors is available to you upon request from the Admitting Office.

I hereby certify ad state that I have read, and that I fully completely understand the above Conditions of Admission and Authorization for Medical Treatment, and that I have signed Conditions of Admission and Authorization for Medical Treatment knowingly, freely, and voluntarily.

_____ _____

Signature of Patient / Parent / Guardian / Conservator Date / Time

_____

If other than Patient, Indicate Relationship

_____ _____

Signature of Witness Date / Time

Revised 7/19/17 JAH

2006 S. Loop 336 W. Ste. 500, Conroe, TX 77304
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ASPIRE Hospital

AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

Please complete the following for your_____.
Name or description of procedure(s) being performed

If you do not have any one that you would like us to release information to please initial here: _____.

I, _____ hereby freely and
Name of Patient Date of birth
voluntarily authorize Aspire Hospital, LLC to release/obtain the following to/from:

_____
Name of Person/Facility

_____
Address

_____
City, State, Zip Code Phone number

My medical records may include information regarding diagnosis and treatment of DRUG, ALCOHOL, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), (HIV Serology) or PSYCHIATRIC DISORDERS. I understand that such information is confidential and is protected by federal law. Those receiving this information will be advised that the federal regulation (42 CFR Part 2) prohibit their making any further disclosure without written consent, or as otherwise permitted by such regulations. This information to be released includes but is not limited to:

□ Radiology Reports/Images □ Other_____

Date of Procedure/Hospitalization: _____

I understand that I have the right to inspect and copy any written information disclosed and the right to revoke this consent at any time by giving written notice to Aspire Hospital, LLC. I UNDERSTAND REQUESTED COPIES WILL BE SUBJECT TO A REASONABLE FEE. I understand that I may not withdraw authorization for a disclosure that is necessary for the purpose of making them available to the hospital for services provided. This authorization will expire in 90 days from the date shown below unless another date is specified. Specification of the date, event or condition upon which consent expires: _____
Date &Time

Patient/Resident <u>MUST</u> sign release regardless of age if alcohol and/or drug treatment involved.

_____ _____
Patient Signature Date & Time

_____ _____
Parent, Guardian, or Representative Signature Date & Time

_____ _____
Aspire Representative Signature Date & Time

Estimated Patient Financial Responsibility

Name of Patient:	Patient Account Number:	DOS:
Estimated Balance Due:	Amount Owed Today:	

I acknowledge that, for this procedure, I am the patient named and/or guarantor (i.e. financially responsible for the patient named).

As such, I agree to the following: **(Please read and initial boxes)**

☐ I agree to pay $_____today. ☐ Please set me up on a payment plan after insurance has been billed.

☐ I agree to pay my share of the balance upon receipt of bill.

☐ I understand this is an **estimated amount for this procedure based on the verification of my insurance benefits**. Any additional balance owed after this payment will be billed directly to me.

☐ I understand I will receive an additional bill from ***Bryan Radiology Associates*** for the interpretation of my procedure.

By my signature below, I acknowledge that I have read and agreed to the above Payment Agreement. I understand that this is a courtesy being extended by the hospital.

Signature of Patient or
Guarantor:_____Date:_____

Relationship to Patient:_____

Signature of Witness: _____ Date: _____

MEDICARE QUESTIONAIRE

Circle correct response

Are you receiving black lung benefits?	Yes	No
Are services to be paid by a government research program?	Yes	No
Has the Dept. of Veteran's Affairs authorized and agreed to pay for your care at this facility?	Yes	No
Was illness/injury due to work related accident/condition?	Yes	No
Are you entitled to Medicare based on end stage renal disease?	Yes	No
Are you entitled to Medicare based on age or disability?	Age	Disability
Are you currently employed or retired?	Employed	Retired
Do you have a group health plan coverage based on your own or your spouse's current employment?	Yes	No

Print Name	
Patient Signature	Date

ASPIRE Hospital