crosstimbers
IMAGING

CT / MRI Outpatient Registration Checklist

Thank you for choosing Cross Timbers Imaging for your upcoming exam(s). CTI respects your time and strives to provide you with very good care. To help expedite the registration process and reduce your wait time, please bring the following completed items with you to your appointment:

☐ Completed Outpatient Preregistration forms for your scheduled test

1. CT / MRI Outpatient Registration Checklist (this form)
2. Registration Information and Authorization Form
3. Patient History for Contrast Media Questionnaire
4. Outpatient MRI/CT History Form

☐ Insurance Card

☐ Government Issued Identification

☐ Insurance co-payment

☐ Physician orders, if applicable

CTI provide many diagnostic and screening procedure. Every procedure is overseen by a specialist who will provide patient centered care. As people are all different, the amount of time each individual needs for their procedure is also different. Please don't be concerned if you are taken to the testing area before someone who arrived prior to you. We will strive to provide each patient with the specialized care they deserve which can cause some fluctuations in the amount of time needed for each test. We will be sensitive to the needs of all of our patients – all of the time.

Cross Timbers Imaging

OUTPATIENT CT/MRI HISTORY QUESTIONNAIRE

Patient Information and History:

Name: ________________________Date of Birth: __________ Age: _____ Height: ______ Weight: _____________

What can we do to make sure you receive very good care today: ____

Do you have someone with you today? ☐ Yes ☐ no If yes, Name: __________________________

Reason you are having this exam: ____

____

Do you have a history of cancer? ☐ Yes ☐ No If yes, what type? _________________________

Did the treatment include: Radiation therapy ☐ Yes ☐ No If yes, what part of the body:_______________

Chemotherapy ☐ Yes ☐ No

List any previous surgeries and approximate date of surgery:

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Have you had any previous scans of the same area we are scanning today? If so, please list.

Exam type_______________________ Where: ___________________ When:_____________________

Exam type_______________________ Where: ___________________ When:_____________________

Please circle if you have any of the following items in your body:

Pacemaker, Defibrillator, Pacing Wires, Cochlear Implant, Hearing Aids, Brain Aneurysm clips or Coils, Gun Shot Wound, Shrapnel, Metal Fragments, Foreign Body or Metal Removed from eyes, Implanted Electrical Devices, Pain Pump, Insulin Pump, Tattoos, Body Piercings, Neurostimulator, Bone Stimulator, Stents in Heart/Legs/Other, Dentures or Transdermal Patches

Female Patients: To be completed for/by all female patients.

Date of start of Last Menstrual Cycle:_______________

☐ Yes ☐ No ☐ Maybe Are you pregnant?

☐ Yes ☐ No Are you currently breast feeding?

☐ Yes ☐ No Have you had a tubal ligation (tubes tied or Essure) or a hysterectomy?

I have read and understood the above information and the information above is correct.

______________________________ ______________________________ _______ _______

Printed Name Patient/Legal Representative Signature Patient/Legal Representative Date Time

Cross Timbers Imaging

PATIENT HISTORY FOR CONTRAST MEDIA

Patient Name:____________________ Date of Birth: __________ Height: ________ Weight:________

Please indicate if you have one of the following:

☐ Yes ☐ No History of "kidney disease" as an adult

☐ Yes ☐ No History of kidney transplant

☐ Yes ☐ No Diabetes

☐ Yes ☐ No Myeloma

☐ Yes ☐ No Lupus

☐ Yes ☐ No Contrast exam performed within the last 7 days?

☐ Yes ☐ No Recent surgeries in the last 2 weeks? If yes, please list:

☐ Yes ☐ No High Blood Pressure

☐ Yes ☐ No Are you taking Metformin or Metformin containing drug combinations (Metformin, Avandamet, Glucophage, PrandiMet, Metaglip, Riomet, Janumet, Kombiglyze, Fortamet, Glucovance, Glumetza, Actoplus Met)

☐ Yes ☐ No Regular us of antibiotics, Advil, Aleve or Motrin

☐ **Yes** ☐ **No** **Have you ever had a reaction to contrast** (iodine, gadolinium or barium)?

If yes, please describe:____

If yes, have you been premedicated today? ☐ Yes ☐ No

☐ Yes ☐ No Active asthma, bronchospasm or bronchitis requiring treatment

☐ Yes ☐ No Heart Disease

☐ Yes ☐ No Currently undergoing Dialysis? If yes, what type: ☐ Hemodyalisis ☐ Peritoneal

☐ Yes ☐ No Fluid restrictions

☐ Yes ☐ No History of allergic (anaphylactic) reaction to one or more allergens

Signed____ Date:__________ Time:__________

(Parent, Patient or Guardian)

To be filled out by the technologist performing your exam

IV performed by:_____________ IV Gauge:_____ IV site: Right/Left Arm/Hand

Creatinine Result: __________mg/dL Result Date:__________

Oral Contrast Type:______________ Amount:__________ Lot#_________ Exp:__________

IV Contrast Type:_______________ Amount:__________ Lot# _________ Rate: _____ cc/sec PSI:_____

Technologist:_______________________________________ Date_________ Time________

Patient Authorization

Section I: Receipt Acknowledgement for the Notice of Privacy Practices

I, ______________________ have been made aware of the notice of Privacy Practices for Cross Timbers Imaging (CTI). I understand that this notice states how CTI may use and disclose my Protected Health Information (PHI).

I UNDERTAND THAT A COPY OF THIS NOTICE IS AVAILABLE UPON REQUEST.

_____ *Initial*

Section II: Consent for Treatment

I authorize CTI to perform all exams, tests, procedures, injections and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition(s).

______*Initial*

Section III: Consent for Release & Acquisition of Medical Records

In order to provide the most accurate reading of my current studies and to assure that I am receiving the highest quality of care, I consent to CTI obtaining any of my previous images, radiology reports, pathology reports, or results of surgical intervention for comparison to my current studies and to track abnormal results. For the same purpose, CTI may release my studies performed at CTI to my treating physicians and medical facilities, upon their request.

In order for CTI to obtain and release my records in a timely manner, I authorize CTI to convey my records and images by secure Electronic Transmission, Courier or Certified Mail.

______*Initial*

Section IV: Release of Records to a Designated Third-Party

In addition to my treating physicians and medical facilities, I authorize CTI to release my records and images to the following individuals. This should include **friends or family members** responsible for picking up your records when you are unable to do so. **PLEASE PRINT**

Name: ____ Phone: _______________

Name: ____ Phone: _______________

______*Initial*

Patient Signature:

By signing below I am verifying that I have read each of the four sections on this page. I understand each section and consent to and agree with the information stated in each section.

_________________________________ _________________

Patient/Legal Representative Signature **Date**

_________________________________ _________________

Patient's Printed Name **Date**

CTI Registration Information

PATIENT INFORMATION (PLEASE USE FULL LEGAL NAME)

Last: ____________________________________ **First:** _____________________________________ **MI:** _________ **Sex:** _____________

DOB: ______________ **SSN#** _________________________ **Marital Status:** ______________ **Home Phone:** ______________

Address: ____ **Cell Phone:** ________________

City: ____ **State:** ____________________ **Zip:** ___________________

Employer: ____ **Work Phone:** _______________

Emergency Contact Name: ____ **Emergency Contact #:** _________________

RESPONSIBLE PARTY INFORMATION

Name: ____ **Relationship:** ___________________________ **Phone:** _____________________

Address: ____ **DOB:** ____________________________ **SSN#:** _______________

Employer: ____ **Work Phone:** _________________________

INSURANCE INFORMATION

On the job injury? ☐ **Yes** ☐ **No** **Motor Vehicle Accident:** ☐ **Yes** ☐ **No** **Injury Date:** __________________________

Primary Insurance

Insurance Company: ____ **Policy #:** _______________________ **Group #:** ___________________

Policy Holder Name: ____ **Policy Holder DOB:** ___________________

Adjuster Name/Phone Number (if applicable): ____

Secondary Insurance

Insurance Company: ____ **Policy #:** _________________________ **Group #:** ___________________

Policy Holder Name: ____ **Policy Holder DOB:** ____________________________

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

I authorize the release of information necessary to process this claim and assign benefits payable for services directly to Cross Timbers Imaging. I authorize the release of any medical information necessary for treatment by my current or future physician or healthcare provider.

I authorize CTI to release to my insurance company any medical information which may be necessary to process my insurance claim. I understand that in the event my insurance company denies this claim I may be held financially responsible for all charges.

I acknowledge that I have read and had the opportunity to receive a copy of CTI's Privacy Notice.

Printed Name: ____

Signature: ____ **Date:** _____________________________