MRN:

PETIMAGING

WELCOME TO PET Imaging

LOCATIONS:

FORT COLLINS
PET Imaging of Northern Colorado
1915 Wilmington Drive, Suite 101
Ft. Collins, CO 80528

Phone: 970.204.0202
Fax: 970.204.0208

TULSA
PET Imaging of Tulsa
6711 South Yale Avenue, Suite 104
Tulsa, OK 74136

Phone: 918.523.7200
Fax: 918.523.7201

NORTHEAST DALLAS
PET Imaging of Dallas – Northeast
1250 Northwest Highway R
Garland, TX 75041

Phone: 972.279.5172
Fax: 972.279.6948

SUGAR LAND
PET Imaging of Sugar Land
17320 W. Grand Parkway S., Suite A
Sugar Land, TX 77479

Phone: 832.595.2713
Fax: 832.595.2714

THE WOODLANDS
PET Imaging of The Woodlands: College Park Plaza
3091 College Park Drive, Suite 340
The Woodlands, TX 77384

Phone: 936.271.4060
Fax: 936.271.4063

Thank you for choosing to have your imaging studies performed at PET Imaging. We provide quality imaging services in each of our locations and our staff strives to provide each of our patients with the individualized care they deserve. It is this compassionate approach, combined with our state-of-the art facilities, comfortable environment and commitment to utilizing the most advanced techniques available that help make PET Imaging a premiere diagnostic center. For your first visit, please fully complete and sign all forms included in your packet. You will need to present these forms to the front desk upon your arrival. If you are unable to complete these forms before your first appointment, please arrive 30 minutes early and we will assist you. If you need to reschedule or cancel your appointment, please call at least 24 hours before your scheduled visit.

PET SCAN PREPARATION

Please bring the following items to your appointment:

- Current insurance card and Driver's license or photo ID
- Payment
- You will be expected to pay your estimated co-payment, co-insurance and/or deductible at the time of your appointment.
- Bring relevant studies and reports to your appointment
- Please arrive 15 minutes prior to your scheduled appointment. The injection is time-sensitive and it is important for you to be on time.

CLOTHING

Wear warm comfortable clothing that has no metal. You will be asked to remove all metal objects including snaps, zippers, buckles and jewelry prior to your scan.

PREPARING FOR YOUR APPOINTMENT

A patient care coordinator will contact you prior to your appointment to discuss detailed preparation instructions and any prescription medications you may be taking. If you are diabetic, please call our office for special instructions.

- We have a television in the patient room. You may want to bring a book or music.
- If you are pregnant, maybe pregnant, or are breastfeeding, contact the PET Imaging office where you are scheduled.
- If you are claustrophobic, please obtain the proper medication from your physician and bring it to the appointment with you. Do not take the medication until the technologist instructs you. If you require medication for claustrophobia, you will need someone to drive you home.
- We do not provide or administer oxygen. If you are on oxygen, please bring enough to last for the two hour procedure plus the drive time to and from our center.
- Your appointment could take approximately 2 hours. The procedure will not affect your ability to drive.
- If you are unable to keep your scheduled appointment time, please call our office at least 24 hours in advance to avoid a $150 missed appointment fee. The missed appointment fee is not covered by insurance. If you fail to provide the required notice, the center may charge you a $150 fee.

RESULTS

The images generated by the PET/CT scan combined with a written report from an interpreting physician will be communicated to your physician within 48 hours of your scan. Your physician will share your results with you.

Our website is www.petimaging.us. We look forward to seeing you and please do not hesitate to call if you have any additional questions or concerns.

PET Oncology-Patient-Paperwork(English).indd 1 4/8/24 09:54

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PATIENT INFORMATION

PLEASE PRINT CLEARLY Today's Date: _____

Patient Name: _____

DOB: ____ /____ /_____ Age: _____ Gender: ☐ Male ☐ Female ☐ Transgender: ☐ M to F ☐ F to M

SSN: _____ Cell Phone: (_____) _____ Phone: (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ May we email you? ☐ Yes ☐ No

Preferred Language: _____

Ethnicity/Race: ☐ White ☐ Hispanic/Latino ☐ Black/African American ☐ Native American

☐ Asian/Pacific Islander ☐ Other

Occupation: _____

☐ Employed/Self Employed ☐ Unemployed ☐ Retired ☐ Disabled

Name of Employer: _____ Work Phone: ( ) _____

Relationship Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other

Living situation: ☐ Lives Alone ☐ Lives with Family ☐ Lives in Nursing Home

☐ Winter Resident ☐ Year Round Resident

Children: ☐ Yes ☐ No If yes, how many? _____

Primary Care Physician: _____ Phone #: _____

Referring Physician (if different): _____ Phone #: _____

_____ Phone #: _____

_____ Phone #: _____

_____ Phone #: _____

_____ Phone #: _____

Patient Initials: _____

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PATIENT INFORMATION

PLEASE PRINT CLEARLY

Patient Name: _____

Emergency Contact Name: _____

Relationship: _____ Phone #: (___) _____

Durable Power of Attorney for Healthcare: ☐ Yes ☐ No _____
Please provide a copy for our records

Relationship: _____

Living Will for Healthcare: ☐ Yes* ☐ No *Please provide a copy for our records

Primary Insurance Carrier: _____

Name of primary policyholder: _____

Policyholder's Date of Birth: _____ Policyholder's SSN: _____

Policyholder's employer: _____

Insurance ID #: _____ Group #: _____

Secondary Insurance Carrier: _____

Name of primary policyholder: _____

Policyholder's Date of Birth: _____ Policyholder's SSN: _____

Policyholder's employer: _____

Insurance ID #: _____ Group #: _____

I certify that the information I have given today is to the best of my ability and as fully and accurately as possible. I will notify the front office/staff to any changes or additions at subsequent visits.

Signature of Patient or Legal Representative: _____ Date: _____

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ONCOLOGY HISTORY FORM

Reason for today's PET scan: _____

When were you diagnosed? _____ If cancer: Type _____ Location _____

THERAPY

Have you had:			Date Last Received	Date of Next Treatment	Date ENTIRE Course Completed
SYSTEMIC THERAPY (chemotherapy, hormonal therapy, Rituxan, interferon, etc.):	☐ Y	☐ N			
RADIATION THERAPY	☐ Y	☐ N			
OTHER (ex. ablation, bone marrow transplant, etc.):	☐ Y	☐ N			

Have you had any injections to stimulate your bone-marrow to produce more blood cells? (Neupogen, Procrit, Neulasta, Aranesp, etc.) ☐ Y ☐ N
If yes, when was your last injection? _____

SURGICAL HISTORY

	Date Performed	What type of procedure?	What area of the body?
RELATING TO YOUR CANCER			
BIOPSY			
PORT-A-CATH PLACEMENT			
OTHER SURGERIES			

COMPARISON STUDIES:

	Date	Body Part	Facility
PET			
CT			
MRI			
BONE SCAN			
X-RAY			
OTHER			

Select the following if it applies to you:

☐ Previous broken bones: _____
☐ Arthritis: _____
☐ Other metal in the body: _____
☐ Recent Infections: _____
☐ Smoker– how many years? _____
☐ Active Hemorrhoids
☐ Feeding or PEG Tube
☐ Pacemaker
☐ Ulcers/GI Disease
☐ Colostomy bag
☐ On oxygen
☐ GE reflux/heartburn
☐ Urine Collection Bag
☐ Use wheelchair or walker

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ONCOLOGY HISTORY FORM

Are you diabetic? ☐ Y ☐ N

If yes, last blood sugar: _____ Controlled by: (check one) ☐ Diet ☐ Pills ☐ Insulin

List current medications you are taking: _____

Females: Are you pregnant? ☐ Y ☐ N ***If you are not sure, contact the technologist immediately!***

Are you breastfeeding? ☐ Y ☐ N When was your last menstrual cycle? _____

Males: Any history of prostate problem? ☐ Y ☐ N Describe: _____

_____

Do you have any trouble lying on your back with your arms over your head for about 30 minutes? ☐ Y ☐ N

Are you claustrophobic? ☐ Y ☐ N

If you are, has your doctor prescribed any medication for you to help relax you? ☐ Y ☐ N

If yes to above, do you have a driver to take you to and from the Center after you take your relaxation medication? ☐ Y ☐ N

When did you eat last? ___:___ AM ☐ / PM ☐ What did you eat / drink (other than water)? _____

When is your follow-up appointment with your doctor? _____

Have you had a COVID-19 vaccine? ☐ Y ☐ N

If yes, date of last vaccine: _____ Vaccine name: _____ Injection site: _____

Are there any other doctors you would like to send your PET scan to? (ex. Cancer Doctor, Radiation Doctor, Surgeon, Primary Care Doctor, Other, etc.) ☐ Y ☐ N If yes, name: _____

_____	_____	_____
Patient Printed Name	Patient Signature	Date

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FINANCIAL RESPONSIBILITY FORM

Dear Patient: _____ Account Number: _____

Our benefits verification team has reached out to your insurance company and obtained your benefits for your upcoming services. Based off the information we were provided we have "ESTIMATED" what your financial responsibility will be for these services.

Deductible	Copay	Co-Insurance	Maximum Out of Pocket	Remaining Out of Pocket

Based off your benefits we estimate the total cost for this service will be:

Service Type: _____

Total Cost of Services	Total Patient Responsibility	Amount Due Today

Comments:

Patient Signature: _____ Date:_____

The amount due is an estimate only and subject to change based on your insurance benefits received at this time

Staff Signature: _____ Date:_____

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PETIMAGING

MEDICAL RECORDS RELEASE FORM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO/FROM PET IMAGING AND ITS ASSOCIATES

PLEASE PRINT CLEARLY

PATIENT INFORMATION:

Patient Name: _____ SSN: _____
please print

Telephone Number: _____ DOB: _____

INFORMATION TO BE RELEASED FROM/TO: ☐ FROM ☐ TO

I hereby authorize the release of information in my medical record from/to (Provider Name):

_____

_____ _____ _____ _____
Address City State Zip Code

_____ _____
Phone Fax

INFORMATION TO BE RELEASED FROM/TO: ☐ FROM ☐ TO

☐ **FORT COLLINS**
PET Imaging of Northern Colorado
1915 Wilmington Drive, Suite 101
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Phone: 970.204.0202
Fax: 970.204.0208

☐ **TULSA**
PET Imaging of Tulsa
6711 South Yale Avenue, Suite 104
Tulsa, OK 74136
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Fax: 918.523.7201

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1250 Northwest Highway R
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Phone: 936.271.4060
Fax: 936.271.4063

TYPE OF RECORD:

☐ ALL MEDICAL RECORDS (pertinent only) (limited 2 years of information)
☐ History & Physical
☐ Discharge Summary
☐ Operative Report
☐ Consultation Report
☐ Psychotherapy notes only
☐ Radiology reports (Specify): _____
☐ Lab Results
☐ Evidentiary Examination
☐ ER Report
☐ Other Information (Specify): _____

PURPOSE OR NEED FOR THIS INFORMATION IS:

(Please check all that apply)
☐ Medical ☐ Insurance ☐ Legal ☐ Personal ☐ Other: _____

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MEDICAL RECORDS RELEASE FORM

PLEASE PRINT CLEARLY

- I authorize the release of the specified information from my medical records.
- I understand information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality laws (HIPAA).
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose my information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I am signing this authorization voluntarily and imaging, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- A photocopy of this release is as effective as the original.
- I have received a copy of this authorization.

SIGNATURE: _____ Date: _____

(Patient / Legal Representative / Guardian)

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AUTHORIZATION FOR IMAGING & PAYMENT OF MEDICAL BENEFITS

PLEASE PRINT CLEARLY

Patient Name: _____ DOB: _____

Thank you for choosing PET Imaging as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality of healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for imaging, payment and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

AUTHORIZATION FOR IMAGING & PAYMENT OF MEDICAL BENEFITS

I give permission to PET Imaging to provide medical services for diagnostic imaging. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to PET Imaging.

PATIENT AUTHORIZATIONS

- By my signature below, I hereby authorize PET Imaging to release medical and other information to the necessary insurance companies and third party payers requires for payment or rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to PET Imaging. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

I have read, understand, and agree to the provisions of this Authorization for Imaging & Payment of Medical Benefits form.

Signature of Patient of Guardian: _____ Date: _____

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CONSENT TO DIAGNOSTIC TESTING

You have the right to be informed about any test your physician has ordered for you. This is so that you may make the informed and knowledgeable decision when consenting to the test.

Your physician has ordered a PET scan to be administered here at PET Imaging. PET is an abbreviation of "Positron Emission Tomography." You will be placed in a machine known as a "PET Scanner." The machine will create an image. The particular machine that will be used to create your scan is a PET/CT machine. This machine will generate two images, one using a PET scanner and the other using a CT scanner. CT is an abbreviation for "Computed Tomography." You will be given an injection of a special tracer in one of your veins and asked to lie quietly for about an hour. In general terms, a PET scanner will then generate an image which indicates which portions of your body you are working quickly to absorb the tracer, while a CT scanner will generate an image which shows certain anatomical structures in your body.

I (we) realize, though rare and generally minor, that there are risks and hazards in connection with the particular test planned for me today. I (we) understand that no warranty or guarantee of any type whatsoever has been made to me as a result of this test or cure of my illness.

I (we) understand that my physician may discover through the procedures/tests to be given to me, other or different conditions, which require additional or different procedures/tests than those planned, I (we) authorize my physician, PET Imaging and such associates, technical assistants, and other healthcare providers as my physician or PET Imaging deem necessary to perform such other procedures/test, which are advisable in their professional judgment.

I (we) consent and authorize, understanding the risks and hazards the administration of a PET scan ordered by my physician and provided by PET Imaging and such associates, technical assistants, and other healthcare providers as my physician or PET Imaging may deem necessary to perform the PET scan.

A physician will interpret the image generated by the PET scanner, and a report will be furnished to the referring physician. A physician, however, will not interpret the image generated by the CT. The physician uses a CT image to assist the physician's interpretation of the PET image and nothing more. I (we) acknowledge by the signature below that my CT image generated by the PET/CT machine will not be interpreted and that no radiological report of any such image will be produced. Further, I (we) release PET Imaging and any interpreting physician from any liability arising out of any matters which could have been included in a radiological report of any CT image generated as part of the PET/CT scan that I am having.

I (we) have been given an opportunity to ask questions about my condition and treatment, risks of non-treatment, the tests to be performed, and the risks and hazards involved, and believe that I (we) have sufficient information to give this informed consent.

I (we) certify that this form has been fully explained to me, that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

_____ _____

Signature of Patient or Legal Representative Date

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AUTHORIZATION TO RELEASE HEALTH INFORMATION AND NOTICE OF PRIVACY PRACTICES

PLEASE PRINT CLEARLY

To protect your privacy, please let us know how you would like us to contact you and who we may release your private health information (PHI) to on your behalf.

☐ No, please do not discuss PHI with anyone. **WARNING: if you choose this option and you become ill and unable to call or come into the office for assistance we may, in our professional judgment, disclose necessary PHI to another medical professional to ensure you are given appropriate medical care.**

☐ Yes, allow communication with:

Name	Relationship	Phone

What kind of PHI may we discuss with your designated family members and/or others involved with your care?

☐ Medical Care ☐ Billing and Payment Information

I _____ , understand the above authorization will remain in effect until I change it in writing. I have been given a copy of the Notice of Privacy Practice for PET Imaging.

Patient Signature	Print Name	Date

Date of Birth: _____

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PETIMAGING

PATIENT PAYMENT POLICY

Dear Patient,

Thank you for choosing PET Imaging as your health care provider. We are committed to providing you with quality health care. We have developed a payment policy to help you understand your responsibility and that of your insurance carrier (if applicable). Please read the policy and sign in the space provided. A copy will be provided to you upon request. If you have questions, please let us know.

1. **Insurance.** Your insurance policy is an agreement between you and your insurance company. We are not a party to your contract. As a courtesy, we will bill your insurance plan for you, if you provide us with accurate information. Please contact your insurance company with any questions you may have regarding coverage.
    a. Non-contracted insurances: if we are not contracted with your insurance company, please be advised that your out-of-pocket costs may be greater than originally anticipated. We will give you an estimate of your costs but the final amount due will be determined by reimbursement from your insurance company.
2. **Non-covered services.** Please be aware the some of the services you receive may not be covered or may not be considered reasonable or necessary by Medicare or other insurers.
3. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that charges for services received are your responsibility whether or not your insurance company pays your claim.
4. **Proof of insurance.** All patients must complete a patient information form before imaging is performed. We will ask for a copy of your current valid insurance card(s) as proof of insurance.
5. **Coverage changes.** If your insurance changes, please notify our office immediately so we can make the appropriate changes to your billing information. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for all incurred charges.
6. **Co-Payments.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company.
7. **Nonpayment.** Please be aware that if you fail to pay your portion of your bill, we may refer your account to a collection agency and you may be discharged from this practice.
8. **Missed appointment policy.** Our policy is to charge an assessment fee to patients who miss their appointments, or who cancel an appointment with less than 24 hours' notice.
    Fees: $150.00 fee for missed PET Scan visits.
    These charges will be your responsibility and billed directly to you. Your insurance will not pay them. Please help us to serve you better by keeping your regularly scheduled appointment.
9. **Payment.** For your convenience, PET Imaging accepts Checks and Credit Cards. We accept Visa, MasterCard, Discover and American Express.

I have read and understand the payment policy and agree to abide by these guidelines. I understand that I am responsible for any portion of my bill that is not covered by my insurance company.

Signature of Patient of Responsible Party	Date
Print Name	Relationship to Patient

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