PET/CT SERVICES OF FLORIDA

Dear Patient:

You may be asked these questions again during the interview with our technologist, please note that we need to collect the most recent, updated information so we can provide you and your physician with an accurate interpretation of your PET/CT scan.

1. **Today's date: _____**
2. **Name: _____ DOB: _____**

   Height _____ Weight _____
3. **Why did your Doctor send you for a PET/CT scan today?**

   _____

   _____
4. **Have you recently been diagnosed with cancer? Y / N If yes, what type?**

   _____
5. **Have you been previously diagnosed with other types of cancer? Y / N If yes, what type?**

   _____
6. **Have you had a biopsy recently? Y / N**
   a. **If yes, of what part of the body? _____**
   b. **When and where was the biopsy done (month/year)? _____**

      _____
7. **Have you ever had Radiation Therapy? Y / N**
   a. **If yes, when was your Last Treatment (month/year)? _____**
   b. **What part of the body was treated? _____**
   c. **What facility were your treatments done? _____**
8. **Have you ever had Chemo Therapy? Y / N**
   a. **If yes, when was your Last Treatment? (Month/year)? _____**
   b. **What facility were your treatments done? _____**

Patients Name: _____ DOB: _____

9. **Have you had any surgeries [Under anesthesia] in relation to your current cancer history? Y / N**

   a. **Where were your surgeries done (facility)? _____**

   b. **When were surgeries done (month/year)? _____**

   c. What types of surgeries were done (i.e. Lung, Breast, Colon)? _____

   _____

10. **Have you had any other diagnostic imaging done for your current cancer history? Y / N**

*****Please list the FACILITY where imaging was performed*****

   a. **CT: (when/where) _____**

   b. **MR: (when/where) _____**

   c. **X-rays: (when/where) _____**

   d. **PET: (when/where) _____**

   e. **Other: (when/where) _____**

When is your next appointment with your Referring Physician? _____

What is the name of your Primary Care Physician? _____

Doctors, Other than the Referring Physician, that you would like the PET scan report to go to

1. _____ **4. _____**

2. _____ **5. _____**

3. _____ **6. _____**

IF THE ABOVE FORM IS COMPLETED BY SOMEONE OTHER THAN THE PATIENT, PLEASE PRINT NAME AND RELATIONSHIP TO PATIENT.

Name and Relationship to Patient: _____

PET/CT SERVICES OF FLORIDA

Please Print Clearly

Name:		**Primary Physician:**	
Address:			
City:	**State:**	**Zip:**	
SSN:	**DOB:**	**Age:**	**Sex: M / F**
Ph. Number:	**Cell Ph. Number:**		
Employer:			
Spouse's Name:	**Spouse's Employer:**		
Primary Insurance:			
Secondary Insurance:			

I request that payment of authorized Medicare, Medicaid, and all other Insurance benefits be made directly to the provider of service on my behalf. I authorize any holder of medical information about me to be released to my specific insurance carrier if needed to determine benefits for the service(s) performed. I understand that I am financially responsible for any non-covered and/or denied charges incurred on my behalf and that it is my responsibility to know my insurance coverage and guidelines. I also give my permission to release any previous films or records from any other facility to be released for comparison or treatment purposes.

I hereby authorize the release of all medical records and images to Dr. McNamee / Dr. Havas and PET/CT Services of Florida. I also authorize PET/CT Services of Florida to release my medical records to my other physicians for treatment and/or comparison purposes.

I understand that PET/CT Services of Florida, will bill my insurance, and it is my responsibility to provide the most correct and updated information regarding my insurance. If I am under the age of 18, my parent or legal guardian will sign.

A copy of this signature is valid as the original

X_____ Date: _____

(Patient/Responsible Party Signature)

Person responsible for payment if other than the patient

Name: _____

Address: _____

Affiliation to patient: _____ Phone/Cell # _____

PET/CT SERVICES OF FLORIDA

Informed Consent Agreement

Consent for: **Positron Emission Tomography (PET) Scan**

I hereby authorize PET/CT Services of Florida and/or such associates to perform the above listed procedure.

The nature and purpose of this procedure is to inject a small amount of radioactive Fluorine18-glucose or similar Fluorine 18 tracer into the blood stream. The tracer will be absorbed into the tissues and enable the scanner to produce an image of those tissues. After the injection has had time to be absorbed I will lie on a table as the PET/CT scanner acquires images of my body.

There are risks associated with this procedure, such as exposure from a small intravenously injected dose of radioactive isotope. Glucose is a common substance in every cell of the body and poses no threat. The Radioactive Fluorine 18 products used must pass multiple quality control measures before it is used for any patient injection.

Alternative to this procedure are Invasive surgery, biopsy, CT scans, MRI, Ultrasound, and X-Rays.

I have been informed of the associated risks and alternatives to this procedure.

I also agree to pay any portion of this service that is not paid by my insurance such as co-payment, deductible amount, non-covered, or other charges allowed.

Patient's Name: _____ Date: _____

Signature: _____

PET/CT SERVICES OF FLORIDA

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ DOB: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following organization is authorized to make the disclosure: **PET/CT Services of Florida** 1541 S.W. 1st Ave. Ste. 101 Ocala, Fl. 34474 or 3404 N. Lecanto Hwy. Beverly Hills Fl. 34465.

3. The type and amount of information to be used or disclosed is the following: Any Diagnostic Imaging Scans to include but not limited to; CT Scans X-Rays, PET Scans, Ultra Sounds, MRI's, Mammograms, and their corresponding Films/Digital images and Digital/Written Reports.

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by PET/CT Services of Florida, and my ordering physician and treating physicians unless otherwise specified.

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company, when law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition _____. If I fail to specify an expiration date, event or condition this authorization will expire in 6 months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. Understand I may inspect or copy this information to be used or disclosed, as provided in CFR 16.524. I understand any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of health information, I can contact the Office Manager.

Signature of Patient or Legal Representative: _____

If signed by a Legal Representative, Relationship to Patient: _____

Date: _____