Memorial MRI and Diagnostic **Memorial Nuclear Imaging**

Exam / Procedure: ____ **Chart #** _______________

Date of Exam: _____________ **Age:** _____ **Sex:** ____________ **Date of Birth:** _____________

Patient's Name:__________________________ **Height:** ____________ **Weight:** ______________

Referring Physician:____________________________**Phone#**______________________________

Nuclear Medicine : Patient History

For our female patients only:

Are you pregnant?	Y / N	
Are you breastfeeding?	Y / N	
Have you had breast mastectomy	Y / N	Rt / Lt
Do you have breast implants?	Y / N	Rt / Lt
Date of your last menstrual period?		
Date of your last mammogram?		

Do you smoke?	Y / N
Have you ever smoked?	Y / N
Do you have COPD?	Y / N
Do you have asthma?	Y / N
Do you use inhalers?	Y / N
Have you had a stroke?	Y / N
Do you have diabetes?	Y / N
Family history of heart disease?	Y / N

mother	father	brother	sister
________	________	________	________

Has your gallbladder been removed? Y / N

Have you ever had the following conditions?	**circle**
Chest pain/discomfort	Y / N
High blood pressure	Y / N
Shortness of breath	Y / N
Dizziness or Fainting	Y / N
Palpations	Y / N
Atrial fibrillation	Y / N
High cholesterol	Y / N
Coronary artery disease	Y / N
Cardiomyopathy	Y / N
Congestive heart failure	Y / N
Mitral valve prolapse	Y / N
Peripheral vascular disease	Y / N
Have you had a Heart attack	Y / N
Date of heart attack?	
Do you have a Pacemaker?	Y / N
Date of pacemaker?	

Please complete if applicable:	**Date of recent**	**Abnormal**
EKG (electrocardiogram)	Y / N	
ECHO (echocardiogram)	Y / N	
Carotid doppler	Y / N	
Treadmill stress test	Y / N	
Nuclear stress test	Y / N	

Please complete if applicable:	**Date of recent**	**# of blockages # of vessels**
Cardiac catheterization		
Angioplasty (PTCA, stent)		
Heart bypass surgery		

List any other chronic illnesses/ Surgeries:

____

____

____

Please continue 2nd page………

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NUCLEAR PATIENT HISTORY DATA SHEET (2)

Patient's Name: ________________________________ **Referring Doctor:** _______________________

Sex: M / H **DOB:** __________

Continued:

What is the main reason for doing this test today? **Circle: chest pain abnormal test results follow-up pre-op clearance**
Other, please list: ____

List **Surgeries**:

____
____
____

List any **medication allergies:**

____

Please list your **current medications** or please provide the list of medications to the technologist.

____________________ ____________________ ____________________ ____________________
____________________ ____________________ ____________________ ____________________
____________________ ____________________ ____________________ ____________________

Technologist Use Only

Patient Information Form for Administration of Unscaled Radioactive Isotopes

Patient Name: ______________________________________ **DOB:** ____________________

Referring Doctor: __________________________ Call Report: ______________________________

Dose__________________mCi Isotope___________________Injection Site R L ___________________

Why is exam being done?

____

____

____

Other Drugs Given (CCK, Lasix, Captopril, Adenosine, etc…..)

Amount given ______________ Initial __________

List technical difficulties, artifact, etc….

____

____

____

Patient Identified by: (Check 3 Method): ◻ Called by Name ◻ Picture ◻ Date of Birth ◻ Other

Signed off by Tech: ____

Memorial MRI and Diagnostic **Memorial Nuclear Imaging**

Patient's Name: ________________________ **Sex:**__________________________ **DOB:** _____________

SS# ______________________ **Address:** ____

City /State/ Zip: ____

Home #: ________________________ **Work #:** ___________________ **Cell #:** _____________________

Insurance Name: ____________________________ **ID#:** ____________________ **Group #:** __________

Primary Card Holder if not Patient: __________________________________**DOB:** __________________

SS# __________________________**WORKER'S COMP INFO:** **Employer:** ___________________________

Date of Injury: ___________**Address:** ________________________ **City / State/ Zip:** _________________

Contact Person: ________________________ **Work #:** _____________________ **Fax #:** ______________

Attorney's Name: _________________________ **Office #:** _______________ **Fax #:** ________________

Treatment & Insurance Authorization

Authorization for Treatment

I hereby consent to treatment by the attending physician and other medical staff for all local anesthetics, tests, surgical and other medial procedures as deemed necessary by myself and the medical staff.

Authorization for Release of Information and Assignment of Benefits

I hereby assign to the above named office, those benefits otherwise payable to me and by any third party as reimbursement of expenses and fees in connection with treatment rendered.

I request that payment of authorized benefits be made directly to the medical provider named above on my behalf.

I FULLY UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL AMOUNTS NOT OTHERWISE PAID BY MY INSURANCE CARRIER.

I certify that the information on this form given by me for payment under title XVIII (Medicare) is correct and complete. I authorize the holder of medical or related information about me, to be released to the HealthCare Finance Administration or other health care coverage entity, and information needed for this or any related health care claim in writing or verbally. I further understand and agree to pay for services or amounts due when appropriate. These charges could include amounts applied to my annual deductible co-payment amounts, and charges denied as not covered by my insurance program or deemed medically unnecessary. I understand that well cared is not covered by Medicare or many other health insurance programs.

Patient Signature:___________________________ Date: ____________________

Medical Records Authorization

I hereby authorize the release of my films and /or medical records as needed for subsequent medical care. In the eve nt of postive findings, I authorize my attending physician to release the results of my biopsy-surgery to the provider named above for their records.

I hereby request that any MEDICAL RECORDS be released to:

MEMORIAL MRI & DIAGNOSTIC
1346 Campbell Road
Houston, Texas 77055
Office #: 713-461-3399 Fax #: 713-461-1969

MEMORIAL NUCLEAR IMAGING
8800 KATY FREEWAY SUITE 105
HOUSTON, TEXAS 77024
Office #: 713-461-3399 Fax #: 713-461-1969

IF SOMEONE OTHER THAN THE PATIENT IS SIGNING THIS AUTHORIZATION, PLEASE STATE RELATIONSHIP WITH PATIENT AND THE REASON PATIENT IS UNABLE TO SIGN: ____
____

Office Use Only: Information Requesting: MRI REPORTS MRI FILMS ULTRASOUND REPORTS

ULTRASOUND FILMS NUCMED FILMS NUCMED FILMS CT REPORTS CT FILMS X-RAYS/FLOURO REPORTS X-RAYS/FLOURO FILMS Other Healthcare Information to the following treatment, condition, or date of treatment:

________________________ _______

YOUR COPY TO KEEP……..

Memorial MRI & Diagnostic / Memorial Nuclear Imaging

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At **Memorial MRI & Diagnostic / Memorial Nuclear Imaging (hereinafter referred to as "the Practice"),** privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide services to you, to process your claims and to bring your health information that might be of interest to you.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us as the telephone numbers or addresses listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How – and why – information is shared

We limit who receives information and what type of information is shared.

- *Sharing information within **the Practice.*** We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.
- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.
- *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy.

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us – whether it's at our office, over the phone or through the Internet.

Memorial MRI & Diagnostic
1346 Campbell Road
Houston, Texas 77055
(713) 461 - 3399

Memorial Nuclear Imaging
8800 Katy Freeway, Suite 105
Houston, Texas 77024
(713) 461 - 3399

Memorial MRI & Diagnostic / Memorial Nuclear Imaging

NOTICE OF PRIVACY PRACTICES

Patient Consent and Acknowledgment of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, **Memorial MRI & Diagnostic / Memorial Nuclear Imaging** creates and maintains health records and other information describing among other things, my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must: agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_______________________________________ _______________________________

(PATIENT'S NAME PRINTED) DATE

____

PATIENT'S SIGNATURE
(OR GUARDIAN, IF A MINOR)