



BLUE STAR IMAGING | BOERNE

112 Herff Road | Suite 150 | Boerne, Texas 78006

Phone: 210.961.4282 | Fax: 210.961.4283

CT SCREENING FORM

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ ☐ Male ☐ Female Weight: _____ Height: _____

What symptoms are you experiencing? _____

Referring Physician: _____

ARE YOU DIABETIC OR HAVE RENAL DISEASE? ☐ YES ☐ NO

CLAUSTROPHOBIC? ☐ YES ☐ NO

PLEASE CHECK BELOW ALL OF THE MEDICAL CONDITIONS THAT APPLY TO YOU:

- | | | | |
|------------------------------|-----------------------------|---|-------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever had IV contrast (dye) injection in the past? (Cardiac Cath, CT, MRI, other) | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you allergic to iodine or iodine containing substance? | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have both kidneys? | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have asthma or lung disease? | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you been diagnosed with hepatitis or jaundice? | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you been diagnosed with epilepsy or seizure disorder? | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have high blood pressure (hypertension)? | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have heart disease? | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have a history of cancer? If yes, explain: | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you been diagnosed with Multiple Myeloma? If yes, explain: | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have a history of stroke? | _____ |

DO YOU HAVE ANY DRUG ALLERGIES? IF YES, PLEASE LIST MEDICATIONS BELOW: ☐ YES ☐ NO

LIST PREVIOUS SURGERIES:

FEMALE PATIENTS ONLY

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is there a chance that you are pregnant? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you currently pregnant? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you had a hysterectomy or tubal ligation? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you currently nursing? |

FORM OF BIRTH CONTROL

- | | |
|--|------------------------------------|
| <input type="checkbox"/> Abstinence | <input type="checkbox"/> Condom |
| <input type="checkbox"/> Birth Control Pills/Patch | <input type="checkbox"/> IUD |
| <input type="checkbox"/> Diaphragm | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Vasectomy | <input type="checkbox"/> None |

I attest that the information I have provided for myself or family member is correct to the best of my knowledge and I hereby give consent for my procedure:

Patient Signature: _____ Date: _____

Technologist Signature: _____ Date: _____



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IV CONTRAST MATERIAL PATIENT CONSENT FORM

Your physician has requested that we perform a diagnostic imaging procedure(CT/MRI), which may require an injection of a contrast material into your bloodstream. The injection may provide additional diagnostic information and improve your exam. Although the vast majority of patients have no side effects from this injection, potential risks may include: pain, bleeding, bruising, swelling, mild headache, nausea, itching, or other vague symptoms for a short time after the injection. Additional allergic reactions in response to the contrast material may include: hives, shortness of breath, or difficulty swallowing.

NOTE TO PATIENTS: It is very important that you inform the technologist if you experience any of the conditions mentioned on the form.

MRI PATIENTS ONLY: People with kidney disease who are given a gadolinium-based contrast material may have a very small risk of developing a very rare disease cause Nephrogenic System Fibrosis (NSF). We screen all MRI patients with criteria recommended by the American College of Radiology. If you meet certain criteria, you may need a blood test to determine your level of kidney function. Presently, this disease has only been found in patients with kidney disease. NSF is often associated with the thickening and tightening of the skin and occasionally other organ and muscles. NSF may rarely continue to get worse and can even cause death. At Blue Star Imaging, we do not give MRI contrast to those at potential risk for developing NSF. However, despite our efforts, there is always a small risk that a patient will develop NSF.

Have you ever had contrast material injected before for a CT, MRI, X-ray or Cardiac Cath? ☐ YES ☐ NO

Did you have any problems with the injection of contrast material? If yes, please explain: ☐ YES ☐ NO

Are you allergic to iodine or iodine containing substances? ☐ YES ☐ NO

Do you have any allergies to medications? ☐ YES ☐ NO

Please List: _____

Are you Diabetic? ☐ YES ☐ NO

If yes, do you take medication to control your Diabetes? (Please list medication)

Are you breastfeeding? ☐ YES ☐ NO

DO YOU HAVE ANY OF THE FOLLOWING:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> Dialysis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Single Kidney | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Kidney Transplant | <input type="checkbox"/> Kidney Surgery | <input type="checkbox"/> Asthma | |

List all the medications you are currently taking:

I give consent to the injection of contrast material if indicated:

Patient Signature _____ **Date:** _____

Technologist Signature _____ **Date:** _____



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HIPAA ACCESS TO PROTECTED HEALTH INFORMATION

Have you had a prior imaging study on the body part you are having examined today? Yes ☐ No ☐

If yes, what type of exam (circle all that apply) CT MRI ULTRASOUND X-RAY

Name of facility where exam was performed: _____

Date of Service: _____

I hereby authorize Blue Star Imaging to request protected health information on my behalf for comparison purposes.

Signature: _____ Date: _____

Print Name: _____ DOB: _____

Please Note:

At the request of your primary care physician or referring doctor, your health information and images may be visible to other physicians for continuing your patient care. The purpose of the request could be for a consultation, second opinion, and/or referral to a specialist.

It is to be understood by all parties that the permitted uses and disclosures of health information must be within the scope of the obligations and responsibilities for continued medical care, defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

____ By initialing here, you are helping streamline the process and allowing the consulting physician to view your images without further consent.

If you wish NOT to have your images available for continued care, please let the front desk know and we will note your account accordingly.

In addition to the caregiver(s) providing services and my insurance company for payment of claims, I would like for the following person(s) to have access to my protected health information (PHI).

Name(s)

Relationship to Patient

BILLING AND COLLECTIONS POLICY

Blue Star Imaging is committed to assisting uninsured or underinsured patients in meeting their payment obligations and to applying consistent and compliant patient billing and collection practices to all patients.

Blue Star Imaging will request payment of billed charges from uninsured/underinsured patients unless the patient qualifies for financial assistance or other programs as outlined below. Ability to pay and eligibility for other funding sources will be taken into consideration at the time services are provided. Blue Star Imaging shall not engage in any Extraordinary Collection Actions before reasonable efforts (as outlined below) have been made to determine whether or not the patient qualifies for financial assistance under the Blue Star Imaging Financial Assistance Policy.

All uninsured patients may be screened for other funding sources (i.e. insurance, third party liability, current eligibility for governmental programs); potential eligibility for other funding programs (i.e. insurance, third party liability, current eligibility for governmental programs); potential eligibility for other funding programs (i.e. Medicaid, Crime Victims, County Indigent, etc.); financial assistance through Blue Star Imaging's Financial Policy; and, ability to pay. Patients who have no other source of funding and do not qualify for financial assistance may qualify for a private pay discount or a payment plan. All patients can obtain a Financial Assistance Policy plain language summary before leaving Blue Star Imaging.

Underinsured patients can be granted the same options for private pay discounts or payment plans on a portion of their charges if they have maxed out their benefits or the services are non-covered by their insurance plan.

Once a patient qualifies for financial assistance no further action shall be taken for amounts qualifying under the Financial Assistance Policy. However, the portion of the patient charges not qualifying for financial assistance will be subject to the same billing and collection actions with other patients as outlined below.

PRESUMPTIVE AND PRIOR ELIGIBILITY PROCESS:

Blue Star Imaging will have made reasonable efforts to determine if a patient qualifies for financial assistance under the presumptive eligibility process outlined in the Blue Star Financial Assistance Policy or if the patient qualifies under prior eligibility determinations. Otherwise, the Notification Process should be followed to establish reasonable efforts.

Under these eligibility determinations, if the patient did not qualify for the most generous assistance available (financially indigent) then the patient shall be notified of ways to qualify as financially indigent and be given a reasonable amount of time before engaging in any Extraordinary Collection Actions.

NOTIFICATION PROCESS:

Once a patient account balance is established and Blue Star Imaging determines the portion of the patient's responsibility, Blue Star Imaging will send a minimum of three post-treatment billing statements over a 60-day period asking the patient to pay starting with the first billing statement. Each billing statement will notify that financial assistance is available for eligible individuals. The final billing statement sent to the patient will contain a plain language summary informing the patient about the Blue Star Imaging Financial Assistance Policy and will notify the patient that the account will be assigned to a collection agency and potentially reported to a credit agency no earlier than 30 days after the date of the final statement. Reporting to a credit agency will not occur until approximately 90 days after the first post-discharge billing statement is mailed to the patient.

In addition to the post-discharge billing statements referenced above, a phone call may be placed to patients asking for payment in full. Each time the patient is called the patient will be informed of the Financial Assistance Policy and how to apply. If payment in full is not possible and the patient does not qualify for financial assistance, then a payment plan will be offered.

Should services be related to an accident in which a third party may be liable Blue Star may file a "Lien" against any potential proceeds or coverage paid by the third party. Blue Star Imaging will not file any liens directly against any patient or their property.

Revenue cycle management has the final authority or responsibility for determining that Blue Star Imaging has made reasonable efforts to determine whether an individual is eligible for financial assistance and may therefore engage in collection actions against the patient.

PATIENT SIGNATURE

DATE