MEDICAL HISTORY QUESTIONNAIRE

Name: _____ D.O.B: _____ Age: _____

Height: _____ Weight: _____

When is your next office visit with the Doctor that ordered this PET-CT Scan? _____

Name of the Doctor and location that ordered this PET-CT Scan:_____

Please indicate your past or current history for the following:

Diagnosis of Cancer: Y or N if yes, Date: _____ Type: _____

Chemotherapy: Y or N if yes, Date of last treatment: _____

Radiation Therapy: Y or N if yes, Dare of last treatment: _____
To what area of your body: _____

Other Therapies: Y or N if yes, please specify: _____

Cancer Surgeries: Y or N if yes, Date: _____ what was done: _____?

Other Surgeries: Y or N if yes, Date: _____ what was done: _____?

Recent Biopsies: Y or N if yes, Date: _____ what body part: _____

Broken Bones: Y or N if yes, Date: _____ what bone: _____

Diabetes: Y or N if yes, Controlled by: __ Diet __Insulin __Oral Medication

Bone Marrow Stimulants: Y or N if yes, Date of last treatment: _____ what drug: _____

Chemotherapy Infusion Port: Y or No if yes, Location: _____

Colostomy: Y or N if yes, Location: _____

Ileostomy: Y or N if yes, Location: _____

Pneumonia: Y or N if yes, Date: _____ Which Lung: _____

Any Recent Vaccinations: Y or N if yes, Date: _____ Type: _____

Any Recent Infections: Y or N if yes, Date: _____ Body part: _____

How long ago was your last meal: _____?

DIABETIC PATIENTS ONLY: (list medications): _____
_____

Previous Studies:	Date:	Body Part:
PET-CT: _____	_____	_____
CT: _____	_____	_____
Other: _____	_____	_____

Patient Signature: _____ **Date:** _____

MEDICAL RELEASE OF INFORMATION FORM

Patient's Name: _____ Date of Birth: _____

Social Security #: _____ Previous Name: _____

I request and authorize _____
(Name of Physician and Clinic/ Practice)

To release the medical information of the above named patient to:

Relationship: **VERITY PET/CT**

Reason for release: **MEDICAL INFORMATION NEEDED FOR SCAN INTERPRETATION/ COMPARISON**

Name of recipient: **VERITY PET/CT**

Address: **6957 W PLANO PARKWAY, SUITE 1300**

City & State: **PLANO, TEXAS** Zip Code: **75093**

Phone: **972-820-1400** Fax: **972-820-1020**

This request and authorization applies to: (initial appropriate line)

X Health Care information relating to the following treatment condition or dates of treatment:
ALL PAST & PRESENT HEALTH ISSUES

__ All Health Care information including information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use.

__ All Health Care information excluding information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use.

X I understand I have the right to revoke this authorization by providing a written request to do so.

_____ _____
Signature of patient or authorized representative Date

_____
Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, ect.)

THIS RELEASE EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices:

This practice reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the "Notice of Privacy Practices"

Patient Name: (print) _____

Patient Signature: _____ Date: _____

Signature of Patient Representative: _____
(Required of the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient: _____

Request for Confidential Communication of Your Protected Heath Information:

Please circle your response to the following:

May we leave messages concerning your appointments with a co-worker, receptionist or secretary that regularly answers your calls? YES NO N/A

May we leave messages on a voicemail at work? YES NO N/A

May we discuss your appointments/ treatment with your spouse? YES NO N/A

If you are over the age of 18, still living at home, may we discuss your appointments/treatment with your parent(s) or guardian? YES NO N/A

If you are over the age of 18, may we discuss your appointments and/or treatment with your children? YES NO N/A

You must inform us in writing of you wish to change the manner in which this office communicates to you.

Thank you!

VERITY PET/CT (dba)
TEXAS HEALTH PHYSICIAN GROUP
PATIENT REGISTRATION FORM DISCLOSURES & CONSENTS

Patient Name: _____ Date: _____
Last Name First Name

ASSIGMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Texas Health Physician Group or the physician individually for services rendered to my dependents, or me, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Texas Health Physician Group is unable to collect from my insurance carrier for whatever reason.

MEDICARE/ MEDICAID/ CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct, I authorize the release of any of my, or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made direct by Texas Health Physician Group or the physician on my behalf.

AUTHORIZED TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I read and been offered a copy of the Texas Health Physician Group. "HIPAA Notice of Privacy Practices" I hereby authorize Texas Health Physician Group, or the physician individually, to release any of my, or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation treatment, consultation or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand that privacy risks of the mail, phone calls and e-mail. I hereby authorize Texas Health Physician Group representative or my physician to mail, call or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and diagnostic test results. I understand that I have the right to reseind this authorization at any time by notifying Texas Health Physician Group to that effect in writing.

LAB/ X-RAY/ DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray or other diagnostic services. I further understand that I am financially responsible for any co-cay or balances due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREAMENT:

I hereby consent to evaluation, testing and treatment as directed by my Texas Health Physician Group, physician or those under his/her supervision.

PATIENT SIGNATURE: _____ DATE: _____

GUARANTOR SIGNATURE: _____ DATE: _____

GUARANTOR NAME (Please Print): _____

Verity
PET/CT

6957 W Plano Parkway, Suite 1300
Plano, Texas 75093 P-972-820-1400 F-972-820-1020

DISCLOSURE REGARDING ANCILLARY SERVICES/RESEARCH PROGRAMS

Ancillary Services

Your physician may refer you to one or more "Ancillary Services" in connection with your medical care. An "Ancillary Service" is a service relating to your medical care or treatment. The following types of services are Ancillary Services:

Magnetic Resonance Imaging (MRI)
Mammography
Ultrasound
Computer Tomography (CT)
Position Emission Tomography (PET)
X-Ray
Infusion Therapy
Bone Density Imaging
Nuclear Imaging
Laboratory
Durable Medical Equipment (DME)
Echo Cardiograph
Sleep Therapy
Audiology

Your Physician may have an economic interest in or business relationship with the company or person who provides the Ancillary Services. You are not obligated to use the provider that your physician refers you to. You are free to use any provider you choose.

If you receive a referral for a MRI, CT, or PET service, the following are other facilities that provide such services in the area:

PET SCAN SERVICES:

- *Southwest Diagnostic Center, 8440 Walnut Hill Lane, Suite 100, Dallas, TX 75231 Phone: (214) 345-8300*
- *PET Imaging of Dallas, 8333 Douglas Avenue, Suite C-20, Dallas, TX 75225 Phone: (214) 373-4200*
- *PET Imaging of Dallas-Northeast, 1250 R Northwest Highway, Garland, TX 75041 Phone: (972) 279-5172*
- *PET/CT of Las Colinas, 7415 Las Colinas Boulevard, Suite 110, Irving TX 75063 Phone: (972) 830-9810*
- *Texas Oncology, 3535 Worth St, Dallas, TX 75246 Phone: (214) 370-1738*

Research Programs:

Your Physician may ask if you would like to participate in a clinical trial or other research program. These programs may be sponsored by a drug company or may be part of a governmental research program. You are not obligated to participate in any research program and your permission will be obtained prior to your participating in a program your physician believes may be appropriate for you.

Please feel free to ask your physician if you have any questions about a particular Ancillary Services or Research Program.

_____ 2015
Date

_____
Patient (or Guarantor) Signature

_____
Printed Name

Texas Health Physicians Group Health Information Exchange Authorization

Texas Health Physicians Group (THPG), participates in health information exchanges as described in the Texas Health Resources Health Information Exchange Patient's Frequently Asked Questions document which may be revised at any time.

A Health Information Exchange (HIE) is an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards. A Health Information Exchange is an electronic health information system that stores your patient health information from multiple healthcare providers participating in the HIEs. It allows your other health care providers to view your past health information for continued care and other uses included in the provider's Notice of Privacy Practices. Your information will be stored within the HIE system, but it will not be visible to or able to be used by providers unless you opt-in to participate.

I understand that my medical records are confidential and cannot be disclosed without my written authorization except when otherwise permitted or required by law. I understand that my medical information may include communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), records related to mental health treatment and alcohol and substance abuse diagnosis or treatment, and I authorize release of that information as part of my medical record. Providers will attempt to exclude clearly identified mental health and substance abuse health information from the HIEs, however some information may be included.

I authorize the above provider to disclose my medical information described above to the HIEs in which THPG participates. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by other providers and such information my no longer be protected.

I understand that treatment or payment cannot be conditioned on my signing this authorization. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization. I may submit a revocation request to the above provider for processing. This authorization will remain in effect indefinitely, unless I revoke it in writing.

The HIE is not able to manage restrictions on disclosure of your health information. A restriction is a request by the patient to not disclose certain information to certain people or companies. If the restriction is or was agreed to by us or other participating HIE healthcare providers, then you must elect to opt-out of the HIE in order to protect your restriction. This must be done at each HIE participating provider you visit.

I authorize release of my medical information to the Health Information Exchanges in which THPG participates:

_____ Yes _____ No

Acknowledgement:
I, the undersigned, certify that I have read and fully understand the information in this Health Information Exchange Authorization form. I understand that if I need to change any information I have provided on this form, I will notify a staff member promptly.

Print Patient's Name	Date of Birth	Address
Signature of patient or authorized representative	Relationship to patient or self	Date
Witness	Title	Date

A "legally authorized representative" is: 1) a legal guardian, 2) an agent authorized in a medical power of attorney or directive to physicians, 3) an attorney appointed by a court, 4) an attorney retained by the patient or the patient's legally authorized representative, 5) a parent or legal guardian of a minor, or 6) a person authorized under the Texas Consent to Medical Treatment Act: the patient's spouse, adult child, a parent of the adult patient, a person clearly identified in advance of incapacity to act for the patient, the nearest living relative, or a member of the clergy. Written evidence of legally authorized representative status must be presented to the clinic prior to release of any information.