ALBANY ADVANCED IMAGING, PLLC
3 ATRIUM DRIVE
ALBANY, NEW YORK 12205

Patient Name: _____ Date: ___/___/___

Address: _____
Street City/State Zip Code

DOB: ___/___/___ Soc. Sec. No.: ___-___-___ Tel.: (___) ___-___

Insurance Guarantor (policyholder): _____ DOB: ___/___/___

Address (if different from above): _____

Patient Insurance Waiver and Notice of Responsibility

As a consumer of medical service, you may have an agreement with an insurance carrier to assist with payment of your medical care. Albany Advanced Imaging, P.L.L.C., maintains agreements with various insurance carriers. Should we participate with your insurance carrier, we are happy to bill your insurance provider directly. Your signature on this form today authorizes us to do so. If your insurance carrier (for whatever reason) chooses not to satisfy your bill in full, you understand and accept complete personal responsibility for any payment due.

Some insurance companies require your doctor to obtain approval before imaging is performed. Albany Advanced Imaging, P.L.L.C. is not responsible for obtaining or justifying pre-certification, authorization or approval. Your signature authorizes Albany Advanced Imaging, P.L.L.C. to perform the examinations(s) requested by your doctor. Albany Advanced Imaging, P.L.L.C. is not responsible in any way should your insurance carrier deny payment for your examination.

Initial Here _____

Receipt of Notice of Privacy Practices ***POSTED ON WALL***

I have been informed of the Notice of Privacy Practices from Albany Advanced Imaging, P.L.L.C. concerning how the use of disclosure of Protected Health Information will be handled by the practice. This notice is posted in the office reception area. I understand I can also receive a copy of this notice.

(Initial here) _____

Signature: _____ Date: ___/___/___

Your relationship to the patient (if applicable) _____

MEDICAL QUESTIONNAIRE – CT

Albany Advanced Imaging
THE RADIOLOGY SPECIALISTS

Please tell the nurse or technologist before your test if you have any of the following, and check all that apply to you:

- □ Previous bad reaction to contrast media (X-ray, CT scan, or MRI dye) injected by vein
- □ Previous reaction to anything else (for example, bee sting or peanut allergy)
- □ Personal history of allergies
- □ Severe or uncontrolled high blood pressure (hypertension)
- □ Heart disease (for example, angina chest pains or congestive heart failure)
- □ Kidney trouble (yourself or among your blood relatives). Explain _____
- □ Diabetes
- □ Multiple myeloma or other blood disease.

Recent use of:

- □ Antibiotics by vein
- □ Cisplatin (cisplatinum) Chemotherapy
- □ High-dose (more than 2 tablets/day) nonsteroidal anti-inflammatory drugs (e.g., ibuprofen, Advil, Motrin, Aleve, Celebrex)
- □ Major surgery or hospital intensive care unit stay within the past 3 months
- □ Pregnancy or possibility of pregnancy
- □ Breastfeeding or nursing a baby
- □ None of the above

Please sign here: _____

Print name: _____ **Date:**___/___/_____

Do not write below this line

Isovue 300/370 _____ml volume given RAC LAC _____ _____ Initials

Comments:

_____

_____

_____