CLIFTON PARK ADVANCED IMAGING, PLLC 648 PLANK RD. CLIFTON PARK, NEW YORK 12065

DOB:/ Tel.: (Patient Name:	Date	e:/
DOB:/ Tel.: (Address:		
Insurance Policy Holder (Person):	Street	City/State	Zip Code
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 assi with payment of your medical care. Albany Advanced Imaging, P.L.L.C., maintains agreement with various insurance carriers. Should we participate with your insurance carrier, we are happ to bill your insurance provider directly. Your signature on this form today authorizes us to do s 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 precertification, 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	DOB:/ Tel.: ()		
As a consumer of medical service, you may have an agreement with an insurance carrier to assi with payment of your medical care. Albany Advanced Imaging, P.L.L.C., maintains agreement with various insurance carriers. Should we participate with your insurance carrier, we are happ to bill your insurance provider directly. Your signature on this form today authorizes us to do s 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 precertification, 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. **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 receiv a copy of this notice. Date:	Insurance Policy Holder (Person):	DOB:	//
As a consumer of medical service, you may have an agreement with an insurance carrier to assi with payment of your medical care. Albany Advanced Imaging, P.L.L.C., maintains agreement with various insurance carriers. Should we participate with your insurance carrier, we are happ to bill your insurance provider directly. Your signature on this form today authorizes us to do s 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 precertification, 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 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. Date:	Address (if different from above):	*	
with payment of your medical care. Albany Advanced Imaging, P.L.L.C., maintains agreement with various insurance carriers. Should we participate with your insurance carrier, we are happ to bill your insurance provider directly. Your signature on this form today authorizes us to do s 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 precertification, 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. ***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 receiv a copy of this notice. ***POSTED ON WALL**** Date:	Patient Insurance Waiver and Notice of Responsibility	7	
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: Date:	with payment of your medical care. Albany Advanced Im with various insurance carriers. Should we participate wit to bill your insurance provider directly. Your signature or If your insurance carrier (for whatever reason) chooses no understand and accept complete personal responsibility for Some insurance companies require your doctor to obtain a Albany Advanced Imaging, P.L.L.C. is not responsible for certification, authorization or approval. Your signature aut P.L.L.C. to perform the examinations(s) requested by your	naging, P.L.L.C., maintain th your insurance carrier in this form today authories to satisfy your bill in fire or any payment due. approval before imaging in obtaining or justifying of thorizes Albany Advance or doctor. Albany Advance	ins agreements , we are happy izes us to do so full, you is performed. pre- pred Imaging, fixed Imaging,
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) Date:	★ Init	tial Here	
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) Date:	Receipt of Notice of Privacy Practices ***Po	OSTED ON WALL***	ŧ
Signature: Date://	P.L.L.C. concerning how the use of disclosure of Protected	d Health Information wi	ll be handled
	(initia	al here)	
Your relationship to the patient (if applicable)	Signature:	Date:	
	Your relationship to the patient (if applicable)		

CPAI PATIENT WAIVER.doc Revised on 07/29/15

MEDICAL QUESTIONNAIRE - CT



Please tell the nurse or technologist $\underline{\text{before}}$ your test if you have any of the following, and check $\underline{\text{all}}$ that apply to you:

•		
Comments:		
Isovue 300/370mI volume given RAC LACInitials	-	
Do not write below this line		
Print name: Date: Date:		
Please sign here:		
□ None of the above		
□ Breastfeeding or nursing a baby		
□ Pregnancy or possibility of pregnancy		
☐ Major surgery or hospital intensive care unit stay within the past 3 months		
(e.g., ibuprofen, Advil, Motrin, Aleve, Celebrex)		
☐ High-dose (more than 2 tablets/day) nonsteroidal anti-inflammatory drugs		
□ Cisplatin (cisplatinum) Chemotherapy		
□ Antibiotics by vein		
Recent use of:		
□ Multiple myeloma or other blood disease.		
□ Diabetes		
☐ Kidney trouble (yourself or among your blood relatives). Explain		
☐ Heart disease (for example, angina chest pains or congestive heart failure)		
☐ Severe or uncontrolled high blood pressure (hypertension)		
□ Personal history of allergies		
□ Previous reaction to anything else (for example, bee sting or peanut allergy)		
☐ Previous bad reaction to contrast media (X-ray, CT scan, or MRI dye) injected by vein		