CT Part A - RETAIL

Last Name: ______________________________

First Name: ______________________________

DOB: _______________ Date: ___________

Height _______________ Weight ____________ lbs/kgs

Please answer the following screening questions carefully:

Please list previous surgeries and their dates:

____

____

Any medical or dental procedures with sedation in the past 24 hours? ☐ Yes ☐ No

Pregnant or Breast Feeding ☐ Yes ☐ No LMP ________________ *(Pregnancy requires informed consent)*

Question	Yes	No	Question	Yes	No
Medication injection device (OnPro)	☐ Yes	☐ No	History of Cancer	☐ Yes	☐ No
Personal History of Diabetes	☐ Yes	☐ No	What type ____________________		
Allergies to IV dye	☐ Yes	☐ No	Chemo _________ Radiation_________	☐ Yes	☐ No
Multiple Myeloma	☐ Yes	☐ No	Previous stroke	☐ Yes	☐ No
Sickle Cell Anemia	☐ Yes	☐ No	Metallic Implants / Surgical Clips	☐ Yes	☐ No
Pacemaker or Neurostimulator	☐ Yes	☐ No	Orthopedic Devices / Prosthesis	☐ Yes	☐ No
Implanted or External Medical Devices	☐ Yes	☐ No	Epilepsy (Seizures)	☐ Yes	☐ No
Asthma/ COPD/Emphysema	☐ Yes	☐ No	Catheter or drainage tube	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No	Claustrophobia	☐ Yes	☐ No
History of Diarrhea in past 2-3 days	☐ Yes	☐ No	Difficulty Swallowing	☐ Yes	☐ No
Self-medicate for today's exam?	☐ Yes	☐ No	Braces/Removable Dental Work	☐ Yes	☐ No
If yes, do you have a driver?	☐ Yes	☐ No	Any recent falls? When ______________	☐ Yes	☐ No

Any previous imaging study related to the reason for today's exam? ☐ Yes ☐ No

Type of Exam _____________________ Facility ____ Date __________

GENERAL CONSENT/ACKNOWLEDGEMENT

I consent to the ordered exam. I understand that I have the right to refuse or stop the exam at any time and I have the right to ask questions and discuss my concerns.

I have read the screening information and answered the above questions accurately.

I understand the risk of having an x-ray while pregnant and I do not believe I am pregnant.

I authorize Akumin, its subsidiaries and affiliates to bill on my behalf Medicare, or any other insurance company providing benefits to me, for services performed by Akumin and I authorize payment to be made directly to Akumin. In Medicare assigned cases, Akumin agrees to accept the Medicare "allowable charge" as the full charge.

I understand that I am responsible for the payment of any patient liability including, but not limited to, deductibles, coinsurance or non-covered charges. Self-pay/Cash pay patients are expected to pay for services at the time services are rendered unless prior payment arrangements have been made.

I have been offered a printed copy of Akumin's Notice of Privacy Practices and I acknowledge receipt of the Patient Rights and Responsibilities.

I have read and I understand, acknowledge and agree to the content of this General Consent form and have had my questions answered. I give my consent to receive electronic communications and survey invitations if applicable.

Patient Signature: ____ Date: ____________ Time: ___________

(Parent or Guardian if patient is a Minor or Incapacitated) Relationship: ________________________________