Metro Region PET Center
Woodburn Nuclear Medicine
3289 Woodburn Road, Suite 050
Annandale, VA 22003

Patient's Medical History

Patient's Name: _____ Date of Birth: _____

Medical Record Number: _____

Date:_____ Height:_____ Weight: _____

Are you a new patient? Yes / No

Are you an inpatient in a hospital or nursing facility? Yes / No

Are you pregnant? Yes / No Date of your LMP? _____
Are you breast-feeding? Yes / No

Briefly describe in the space below why you were referred for a PET/CT or CT scan:

Has it been at least 6 hours since you've consumed any food or drink (other than water)? Yes / No

Over the past 6 months have you experienced any weight loss? Yes / No

- If yes, approximately how much? _____Lbs.

Do you currently have any type of infection? Yes / No

- If yes, please provide details: _____

Are you currently on, or have you recently completed, intravenous chemotherapy? Yes / No

- If yes, please list Medication(s):_____
- Date the last cycle ended: _____

Are you on oral chemotherapy or a hormonal therapy regimen? Yes / No

- If yes please list: _____
- Date of the last dose: _____

Have you received any unconventional therapies (e.g.: immunotherapy, experimental protocol therapy, etc.)? Yes / No

- If yes, please provide details: _____
- Date of the last treatment: _____

Patient's Name: _____ Date of Birth: _____

Have you received radiation therapy? Yes / No

- o If yes, indicate the anatomical part of your body: _____
- o Date of last therapy: _____
- o Is more radiation therapy planned? Yes / No

Please list all recent surgical procedures below:

1)_____ date: _____

2)_____ date: _____

3)_____ date: _____

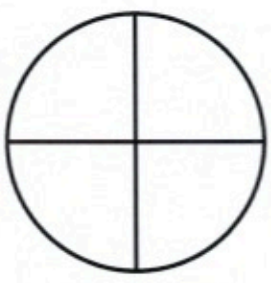
4)_____ date: _____

Please list all medications you are currently taking:

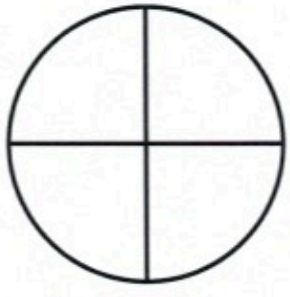
_____ _____ _____

_____ _____ _____

Breast Cancer Patients: Please place a dot in the diagram below to indicate the location of your original tumor.



Right Breast



Left Breast

Patient's Name: _____ Date of Birth: _____

PLEASE COMPLETE THIS PAGE IF THIS IS YOUR FIRST VISIT TO OUR FACILITY

List all major medical problems: _____

_____

_____

Have you had a biopsy? Yes / No

- If yes, give date and results. _____

Have you been diagnosed with cancer? Yes / No

- If yes, when was the cancer diagnosed? _____
- Specify the type of cancer. _____
- How did your physician diagnose the cancer?

  _____

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THIS SECTION TO BE FILLED OUT BY STAFF ONLY

Did the patient bring outside films or discs? Yes / No

- If yes, provide the date: _____

Have previous reports been provided? Yes / No

- If yes, provide the date: _____

ccs_____

_____

Patient's Name: _____ Date of Birth: _____

The Centers for Medicare and Medicaid Services, the Federal agency which administers Medicare and Medicaid, now requires that we collect the following information from all patients. This will be kept confidentially in your Electronic Medical Record.

More information regarding this requirement can be found at www.CMS.gov. We apologize for the inconvenience and appreciate your understanding.

Race (please check one):

o White/Caucasian o American Indian/Alaska Native o Asian

o Black/African American o Native Hawaiian/Pacific Islander

Ethnicity (please check one):

o Hispanic/Latino o Non Hispanic/Non Latino

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Authorization to Receive and to Disclose Protected Health Information

Patient's Name: _____

Date of Birth: _____

I authorize the disclosure of my medical records and other documentation that pertains to my healthcare, treatment, insurance billing and/or benefit eligibility **to** Metro Region PET Center/Woodburn Nuclear Medicine.

I also authorize Metro Region PET Center/Woodburn Nuclear Medicine to disclose my medical records for the purposes of monitoring my care and treatment, insurance billing and/or benefit eligibility.

I understand that this information will be forwarded by either facsimile transmission, email, regular mail or courier and that Metro Region PET Center/Woodburn Nuclear Medicine will take every precaution to protect my information while it is in their custody. However, I release Metro Region PET Center/Woodburn Nuclear Medicine from any liability for breach of confidentiality or misdirection of these records once they leave the facility's control.

I understand these records may contain sensitive information including documentation pertaining to HIV testing, medical reports and administrative data.

I understand that I have the right to revoke this authorization at any time in writing. This revocation will not pertain to information that has already been released in response to this authorization. I further understand that this revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim.

This facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Signature of Patient or Guardian **Date**

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Assignment of Insurance Benefits

Metro Region PET Center / Woodburn Nuclear Medicine is pleased to extend the courtesy of billing _____ **for you**
PATIENT'S INSURANCE CARRIER
for today's services. We will make every effort to collect the fee for today's visit from the aforementioned insurance carrier.

I, _____**, assign the benefits of my medical**
PATIENT'S NAME
insurance coverage from the aforementioned insurance carrier, policy number _____**, to Metro Region PET Center / Woodburn Nuclear Medicine, for charges pertaining to medical treatment extended to me on** _____**(Date).**
DATE OF SERVICE
I grant Metro Region PET Center / Woodburn Nuclear Medicine the right to pursue any appeals with my aforementioned insurance carrier necessary to secure full policy benefits. If the insurance company requests my medical records, I authorize Metro Region PET Center / Woodburn Nuclear Medicine to release such information to help secure payment.

I understand that I will be responsible for charges resulting from today's visit if my insurance coverage has lapsed, if I was ineligible for coverage or my insurance company denies payment. I further understand that any portion of today's charges not paid by my insurance company will be my responsibility and must be paid upon the receipt of the statement. I may have the option to set up a mutually agreeable payment plan if requested. I understand that should it become necessary to turn my account over to an outside collection agency I will be responsible for collection costs, attorney fees, litigation expenses and court fees.

_____ _____
Signature of Patient or Guardian **Date**

Metro Region PET Center/Woodburn Nuclear Medicine
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703-698-5593

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

Patient's Name: _____

Patient's Date of Birth: _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain *Patient Rights* regarding my protected health information.

I understand that Metro Region PET/Woodburn Nuclear Medicine Center may use or disclose my protected health information for treatment, payment and/or health care operations - which means for providing health care to me, the patient, handling billing and payment and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Metro Region PET/Woodburn Nuclear Medicine Center has a detailed document called '***Notice of Privacy Practices***'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice' before* signing this agreement. If I ask, Woodburn Nuclear Medicine / Metro Region PET Center will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review a copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Metro Region PET Center/ Woodburn Nuclear Medicine to use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Metro Region PET Center/Woodburn Nuclear Medicine has already taken action relying on this consent.

_____ _____
Signature Date

_____ _____
Relationship to patient (if signed by another party) Date

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice"*, at any time by contacting Metro Region PET Center/Woodburn Nuclear Medicine (refer to contact information above).