Griffin Imaging, LLC

INFORMED CONSENT FOR "CAT" SCAN WITH CONTRAST MATERIAL

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ AND FULLY UNDERSTAND ITS CONTENTS

Patient Name: _____ Date: _____

The following has been explained to me in general terms and I understand that:

1. Diagnosis requiring this procedure is: _____
2. The contrast material is given through a small needle placed into a vein, usually on the inside of your elbow or on the back of your hand. Normally, contrast material is considered quite safe; however, any injection carries slight risks of harm including injury to a nerve, artery, or vein, infection, or reaction to the material being injected. Occasionally, a patient will have a mild reaction to the contrast. The physicians and staff of Griffin Imaging, LLC are trained to treat these reactions. Very rarely (1:40,000) death has occurred related to contrast administration; the risk of such severe consequence is similar to that from the administration of Penicillin.

The x-ray study, utilizing the CAT Scanner (Computerized Axial Tomography), is a special x-ray device that allows the production of photographs of serial slices through portions of the body. You will feel no sensation to this procedure, but your cooperation and remaining still is required. The technologist or radiologist will instruct you throughout the procedure. It is necessary to inject a contrast material in some studies to visualize the blood vessels and identify them to determine if there is some unusual formation, blockage, etc. A special x-ray "dye" is utilized by injecting it into one of you veins. This examination allows detailed evaluation of the organs and vessels to determine abnormalities.

Two different types of contrast agents are available at this time. It appears that "low osmolar" or "non-ionic" contrast may be safer for patient use. For this reason, Griffin Imaging, LLC has chosen to use only the "low osmolar" or "non-ionic" contrast agent. If you have any questions, please ask the technologist or the attending radiologist.

Some individuals are at a higher risk for adverse reactions to contrast. These include:

- People who have already had a moderate or severe "allergic-like" reaction to contrast material that required treatment.
- People with severe allergies or asthma
- People with severe or incapacitating heart disease
- People with multiple myeloma, sickle cell disease, polycythemia, or pheochromocytoma.
- People with severe kidney disease, particularly disease caused by diabetes.

If you have any of these conditions, or if you are uncertain about any of these conditions, please inform the x-ray technologist or the attending radiologist.

3. MATERIAL RISKS OF THIS PROCEDURE:

As a result of this procedure being performed, there may be material risks of: INFECTION,

ALLERGIC REACTION, DISFIGURING SCAR, SEVERE LOSS OF BLOOD, LOSS OR LOSS OF FUNCTION OF ANY LIMB OR ORGAN, PARALYSIS, PARAPLEGIA OR QUADRAPLEGIA, BRAIN DAMAGE, CARDIAC ARREST OR DEATH.

4. In addition to these material risks, there may be other possible risks involved in this procedure, including but not limited to: Allergic Rash, Swelling of the lips or eyelids, and Difficulty Breathing.

5. The likelihood of success of the above procedure is:
( ) Good ( ) Fair ( ) Poor

6. The practical alternatives to this procedure would be: Nuclear study, X-ray linear tomography, or Ultrasound studies.

7. It is our judgment that the performance or lack of performance of this diagnostic procedure will not necessarily influence the patient's prognosis other than to possibly withhold diagnostic information from the referring physician.

I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of this procedure.

I understand that during the course of the procedure described above it may be necessary or appropriate to perform additional procedures which are unforeseen or not known to be needed at the time this consent is given. I consent and authorize the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures as they may deem necessary and appropriate.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND ITS CONTENTS, AND THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS OR STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I HAVE SIGNED THIS FORM. I ALSO HAVE RECEIVED ADDITIONAL INFORMATION INCLUDING BUT NOT LIMITED TO THE MATERIALS LISTED BELOW RELATING TO THE PROCEDURES DESCRIBED HEREIN.

I voluntarily consent to the medical personnel under the direct supervision and control of

Dr. _____ to perform such procedures described or otherwise referred to herein.

_____ _____

Witness Person giving consent

_____

Relationship to patient if not the patient

Patient unable to sign because:

_____

Additional materials used, if any, during the informed consent process for this procedure include:

_____

PATIENT CONSENT

Use/ Disclosure of Health Care Information

Patient's Name: _____ Date of Birth: _____

SS#:_____ Previous Name: _____

I understand that the patient's health information is private and confidential. I understand that Griffin Imaging, LLC works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Griffin Imaging, LLC and it's employee's may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payments, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual.

Griffin Imaging, LLC has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement.

Griffin Imaging, LLC may update this "Notice of Privacy Practices". If I ask, Griffin Imaging, LLC will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Griffin Imaging to limit how the patient's personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Griffin Imaging, LLC does not have to agree to my request. If Griffin Imaging, LLC does agree to my request, I understand that Griffin Imaging, LLC would follow the agreed upon limits.

I may cancel this consent in writing at any time by doing one of the following:

- Signing and dating a form that Griffin Imaging, LLC can give to me called a "Revocation of Consent for Use and Disclosure of Health Care Information", or
- Writing, signing, and dating a letter to Griffin Imaging, LLC. If I write a letter, it must state that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment and health care operations.

If I revoke this consent, Griffin Imaging, LLC does not have to provide any further health care services.

My signature below indicates that I have been given the opportunity to review a current copy of Griffin Imaging, LLC "Notice of Privacy Practices". My signature means that I agree to allow Griffin Imaging, LLC to use and disclose the patient's personal health information to carry out treatment, payment and health care operations.

Please indicate phone number where we can leave confidential information: _____

List any other individual we are allowed to speak with: _____

_____Regarding my bill (only) _____ Regarding testing results (only) _____Regarding both

_____ _____ _____

Patient or legally authorized individual signature **Date** **Time**

_____

Relationship to patient if signed by anyone other than patient (parent, legal guardian, etc.)

_____ _____ _____

Witness **Date** **Time**

GRIFFIN IMAGING

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Specializing In High Field MRI, CT, Ultrasound & Bone Density Scans
www.griffinimagingradiology.com

RECORD RELEASE FORM

I hereby request and authorize Griffin Imaging, LLC to obtain copies of my medical records and/or x-ray films from _____.

Patient Name: _____

Date of Birth: _____

SSN: _____

Pt Acct #: _____

Exam: _____

Date of Service:_____

Referring Phys.:_____

Please fax any and all records pertaining to the above listed date of service and exam to Griffin Imaging, Attention: Dr. Ronald C. Gay at (770) 229-4632.

_____
Patient Signature

_____
Date

_____
Witness

_____
Date