# HEART SCAN OF CHICAGO PATIENT CONSENT

**LANGUAGE SERVICES** ______ (please initial)

 I accept interpreting services provided by imaging center I request friend or family member to interpret

 Language Requested: ________________  Form read to patient by: ________________

**INFORMED CONSENT FOR TREATMENT** ________ (please initial)

I hereby consent to the administration and performance of CT scanning with contrast by personnel at Heart Scan of Chicago. The nature and purpose of the procedure, the risks involved, and the possibility of complications have been fully explained to me and I understand them. I recognize that the practice of medicine is not an exact science and the procedure may not have all of the benefits I intend. There can be adverse consequences not ordinarily anticipated. I am aware that there are always risks and dangers to life and health associated with contrast material (iodine dye), medications, medical procedures and treatments. I authorize Heart Scan of Chicago to request and receive information, including my medical record, from my treating physician (s) or agents. YES____ (please initial) NO_____

**RELEASE OF RESPONSIBILITY FOR VALUABLES** ________ (please initial)

I acknowledge that Heart Scan of Chicago WILL NOT be liable for any loss or theft of any personal property of mine, whether such loss or theft is caused by any patient, visitor, guest, agent or employee of Heart Scan of Chicago. I hereby release and exonerate Heart Scan of Chicago from any loss or theft of my personal property.

**ASSIGNMENT OF BENEFITS** ________ (please initial)

I currently maintain insurance coverage, which will reimburse the charges at Heart Scan of Chicago and its treating physicians for medical care provided to me. In consideration of those services, I hereby assign, transfer and convey to Heart Scan of Chicago, its affiliates, and its treating physicians, all of my rights, title and interest in my medical insurance for medical expense reimbursement, including, but not limited to adding dependent eligibility, and to have a policy continued or issued in accordance with the terms and benefits under any insurance policy continued or issued.

**PAYMENT GUARANTEE** ________ (please initial)

I HEREBY ASSUME FULL RESPONSIBILITY FOR AND AGREE TO PAY ALL COSTS, CHARGES AND EXPENSES INCURRED BY ME FOR THE MEDICAL CARE PROVIDED BY HEART SCAN OF CHICAGO, ITS AFFILIATES AND ITS TREATING PHYSICIANS; IF MY MEDICAL INSURANCE COVERAGE IS NOT SUFFICIENT TO SATISFY SUCH COSTS, CHARGES AND EXPENSES IN FULL, OR, IF FOR WHATEVER REASON MY INSURANCE CARRIER DENIES PAYMENT(S) FOR THESE PROCEDURES AT HEART SCAN OF CHICAGO, I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE. I AGREE TO PAY THE ESTABLISHED RATES OF HEART SCAN OF CHICAGO, ITS AFFILIATES AND ITS TREATING PHYSICIANS FOR ALL SERVICES, OVERSIGHT AND SUPPLIES RENDERED TO ME, WHICH MAY BE BILLED SEPARATELY.

**RECEIPT OF NOTICE OF PRIVACY PRACTICES** _______ (please initial)

I acknowledge that I have received Heart Scan of Chicago's Notice of Privacy Practices. I understand that the notice describes the uses and disclosures of my protected health information by Heart Scan of Chicago and informs me of my rights with respect to my protected health information.

**REQUEST FOR DISCLOSURE OF MEDICAL RECORDS** ________ (please initial)

I hereby authorize a copy of the record to be transferred to my physician. I am legally authorized to make this request.

Upon signing this consent, I acknowledge that I have read and understand the foregoing and accept its terms.

Patient Signature: ________________________________ Date: ____________________

Parent or Guardian Signature: __________________________ (Pt under 18yrs old) Date: ____________

Date of Service: _________________

Heart Scan of Chicago Employee Witness Signature: ___________________________Date: _________

*REV: 01/09*