Name _____

Primary Care/Referring Physician_____

Cardiologist Ordering Testing_____

CALCIUM SCORE SCREENING INFORMATION

Your Known Risk Factors

__ Diabetes
__ High Blood Pressure
__ High Cholesterol Cholesterol medication: Yes____ No___
__ Smoker __Present __Former

__ Positive Family History of Heart Disease

Signature Date of Birth

For Women:
Are you pregnant or do you think there is **ANY** chance you could be pregnant? _____**NO** ___**YES** If yes: please notify technologist.

_____
Patient Signature

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CARDIOVASCULAR CONSULTANTS
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CONSENT FOR CALCIUM SCORE

The Coronary Cardiac CT (computed tomography) for Calcium scoring is a non-invasive way of obtaining information about the location and extent of calcified plaque in the coronary arteries. Calcium detection does give us a way to determine the total plaque burden of the arteries surrounding the heart, but it does not, by itself, indicate a blockage or specific site of blockage in the artery. Patients with a high calcium score may be recommended to follow up with his/her primary physician who may in turn recommend further testing. Other specific radiological testing should be considered for conditions other than the detection of coronary calcification for determination of calcium score.

By signing this form you are indicating that you understand that you may be advised to seek the consultation of a cardiologist and that this study may lead to subsequent studies, exams or procedures. Also by signing this form you are indicating that you understand that there are limitations on the early detection of disease.

By signing this form you understand that you will be exposed to a small amount of radiation for a short period of time. This facility is equipped to handle emergencies during the test and that personnel have been trained for emergency procedures.

All risks and benefits of this test have been explained to me and I voluntarily accept such risks associated with this test.

_____

Print Name Date of Birth

_____

Patient Signature Date

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Insurance Waiver

Patient Name: _____ **Date _____**

PROVIDER STATEMENT:
Based on the information that you have provided to us, we believe that it is unlikely that your insurance company will provide coverage for the following items or services:

ITEM(S) / SERVICE (S)	ESTIMATED CHARGE (S)
Calcium Score 75571	**$100**

REASON CODES (check all that apply)

_____ Patient did not have insurance card, patient agrees to call information back to our phone number _____ by _____ or will be billed as self pay.
(Phone #) (Date)

_____ Our Facility/Provider is not a contracted facility/provider for the above listed service(s).

__X__ Your insurance company may determine that the following service is not a covered benefit for the diagnosis that was provided to use by your physician

_____ You have reached the maximum benefit provided by your insurance company for this service, according to your insurance carrier. Certain frequency limitations may apply.

__X__ Your insurance company does not usually provide for screening or research testing.

_____ Patient understands that the physician from which (s)he will be receiving health services is not the PCP of record. Futhermore, patient understands that the insurance company will not pay for any health services rendered by a provider who is not the members' current PCP of record.

_____ Other:
(explain) _____

PATIENT'S STATEMENT:

I want to receive these items or services. I understand that my insurance company will not be billed. I understand that I am personally and fully responsible for the payment.

_____ _____
Signature Date