



**PET/CT ORDER INTAKE FORM**  
**TRIDENT PET/CT OF SAVANNAH - PATIENT INTAKE**

Your Initials:	Who Called:	Date/Time Called:	/ / @
Ref. Dr: _____ <small style="margin-left: 100px;">Last name, First name</small>		Off Loc: _____	
Phone: (____) _____ - _____		Appt. Date: ____/____/____ Time: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	

**PATIENT INFORMATION:**

Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alt. Ph: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Ins. Co: \_\_\_\_\_ Ins. ID#: \_\_\_\_\_ Grp#: \_\_\_\_\_

2<sup>nd</sup> Ins. Co: \_\_\_\_\_ 2<sup>nd</sup> Ins. ID#: \_\_\_\_\_ 2<sup>nd</sup> Grp#: \_\_\_\_\_

**DX Codes (ICD10):**

\_\_\_\_\_

(Must code to the highest 4th or 5th digit)

**Primary DX Code Description:**

\_\_\_\_\_

Patient Diabetic?  Yes  No      Sex:  M  F

Previous Imaging Studies?  Yes  No      If Yes, What type and Where? \_\_\_\_\_

<b><u>PET/CT Codes</u></b>	<b><u>CT w/IV Contrast</u></b>	<b><u>CT w/o IV Contrast</u></b>	<b><u>CT w &amp; w/o IV Contrast</u></b>
78815 <input type="checkbox"/> Torso	70491 <input type="checkbox"/> Neck	70490 <input type="checkbox"/> Neck	70492 <input type="checkbox"/> Neck
78816 <input type="checkbox"/> Head-to-Toe	71260 <input type="checkbox"/> Chest	71250 <input type="checkbox"/> Chest	71270 <input type="checkbox"/> Chest
78814 <input type="checkbox"/> Limited	74177 <input type="checkbox"/> Abd/Pelv	74176 <input type="checkbox"/> Abd/Pelv	74178 <input type="checkbox"/> Abd/Pelv
78809 <input type="checkbox"/> Brain Metab	74160 <input type="checkbox"/> Abd	74150 <input type="checkbox"/> Abd	74170 <input type="checkbox"/> Abd
A9552 <input type="checkbox"/> FDG Dose	72193 <input type="checkbox"/> Pelv	72192 <input type="checkbox"/> Pelv	72194 <input type="checkbox"/> Pelv
A9586 <input type="checkbox"/> Amyvid Dose			
A9588 <input type="checkbox"/> Axumin Dose			



**CONSENT TO DISCLOSE MEDICAL INFORMATION**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

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Please check one of the following:

I give permission to the employees of Trident PET/CT of Savannah, a division of American Oncology Partners, P.A. to disclose my Protected Health Information to me and the following individual(s):

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

I request that all my Protected Health Information be disclosed ONLY to me and no other individual(s).

I understand that I may revoke or change this Consent at any time by filling out another consent form to replace this one.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guarantor (Signature)



## FINANCIAL POLICIES AGREEMENT

Dear Valued Patient,

**Thank you for choosing Trident PET/CT of Savannah, a division of American Oncology Partners, P.A. (TPCS/AOP), as your health care provider.** Our physicians are committed to providing you with the highest quality care.

Prior to receiving treatment, please read and acknowledge our patient financial policies:

- You agree to provide TPCS/AOP with current and accurate insurance, health care benefits program and/or other payer information, and to immediately notify us if your coverage changes.
- You agree that these policies apply to you, and may change from time to time without notice.
- You acknowledge that TPCS/AOP will bill your insurance plan or program for services provided by TPCS/AOP and you agree you are assigning your right to receive payment or benefits from such insurer or program to TPCS/AOP and you are authorizing payment to be made directly to TPCS/AOP.
- You agree you are responsible for payment to TPCS/AOP of all co-pays, deductibles and co-insurance applicable under your insurance policy, plan or program. You understand that payment of such amounts is due at the time of service.
- Depending on your insurer, plan or program, some services may not be covered. If your insurance does not authorize or cover a service or treatment and you nevertheless decide to receive such service or treatment, you agree that you are responsible for payment. This applies to all payers in accordance with all applicable law and regulation and payer requirements (including any "advance beneficiary notice" (ABN) which may be applicable under Medicare).
- To facilitate payment of claims, to perform internal operations and to coordinate your care with other health care providers, TPCS/AOP will use your personal health information internally and will share such information with your insurance policy and certain business associates of TPCS/AOP in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal and state law and regulation.
- TPCS/AOP owns and operates AON Pharmacy, LLC, a specialty pharmacy that provides certain pharmaceuticals that may be prescribed by your TPCS/AOP physician and may be covered under your medical or pharmacy benefits plan or program (such as Medicare Part B or Part D). You are not obligated to use AON Pharmacy, LLC and may have your prescriptions filled wherever you choose. However, if you select AON Pharmacy, LLC to fill TPCS/AOP-issued prescriptions, then this policy and all other TPCS/AOP patient financial responsibility policies will also apply to the items and services provided to you by AON Pharmacy, LLC.
- You acknowledge that laboratory and/or radiology services may be necessary as part of your care and treatment which may be performed by TPCS/AOP clinicians at TPCS/AOP's own facilities. In some cases, services may be provided by outside facilities, in which case, you understand that you may receive a separate bill directly from the outside provider.
- If you make a payment to TPCS/AOP that results in a surplus on your account (i.e., a credit balance), TPCS/AOP may hold that amount as a deposit against charges that are subject to ongoing claims processing or charges for scheduled future services, and TPCS/AOP may apply the surplus against such pending or future scheduled charges. If a surplus still remains after applying all credits, or if at the conclusion of your care a credit balance remains which is not subject to return to your insurer or other payer, TPCS/AOP will refund the credit balance to you. However, you agree that any refund under \$10.00 will be made only if you make a written request and, in any event, any credit balance under \$10.00 will be forfeited if a refund request is not received within five (5) years after the conclusion of your care.



**I HAVE READ, UNDERSTAND, AND AGREE TO THE PATIENT FINANCIAL POLICIES. A COPY IS AVAILABLE TO THE PATIENT UPON REQUEST.**

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guarantor (Signature)

**For office use:**

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Trident PET/CT of Savannah/AOP Employee (Signature)



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of the Trident PET/CT of Savannah, a division of American Oncology Partners, P.A., (TPCS/AOP) Notice of Privacy Practices.

This notice is available in hard copy by verbally requesting a copy at the front desk of any TPCS/AOP facility or by submitting a request in writing to the corporate office at Trident PET/CT of Savannah, a division of American Oncology Partners, P.A., 9160 Forum Corporate Parkway, Suite 350, Fort Myers, FL 33905.

You may also view and/or print a copy of the Notice of Privacy Practices by visiting [AONcology.com/policies/TPCS\\_NPP.pdf](http://AONcology.com/policies/TPCS_NPP.pdf)

Date: \_\_\_\_\_

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Patient (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guarantor (Signature)

\_\_\_\_\_  
Date



By signing below, I authorize Trident PET/CT of Savannah, a division of American Oncology Partners, P.A., (TPCS/AOP) its affiliate and subsidiary entities, and AON Pharmacy, LLC (and any authorized TPCS/AOP texting service vendor) to contact me by SMS text message for health-related notifications, including appointment reminders and billing communications.

I understand that message/data rates may apply to messages sent by TPCS/AOP under my cell phone plan.

I know that I am under no obligation to authorize TPCS/AOP to send me text messages. I may opt-out of receiving these communications at any time by responding with "STOP".

I understand that text messages are not a substitute for professional or medical attention.

By signing below, I indicate I am the person legally responsible for all use of mobile accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services.

PLEASE MARK THE FOLLOWING:

- I consent to receiving information via text. I understand I can withdraw my consent at any time.  
Text Cell # \_\_\_\_\_
- I do not consent to receiving any information via text. I understand that I can change my mind and provide consent later.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient (Signature)