

PREPS FOR ULTRASOUNDS

ABDOMEN	NOTHING TO EAT OR DRINK AFTERMIDNIGHT, OR FOR AT LEAST FOR THE LAST 6 HRS.
AORTA	NOTHING TO EAT OR DRINK AFTER MIDNIGHT ,OR FOR AT LEAST FOR THE LAST 6 HRS.
BIOPHYSICAL	20 OUNCES OF WATER 1 HR. PRIOR & DON'T' USE THE RESTROOM AFTER DINKING
KIDNEY	NOTHING TO EAT OR DRINK AFTERMIDNIGHT, OR FOR AT LEAST FOR THE LAST 6 HRS.
OB	32 OUNCES OF WATER, STARTED 1 HR BEFORE EXAM. HAVE WATER FINISHED WITHIN 10 MIN. DO NOT USE RESTROOM AFTER DRINKING.
PELVIC	32 OUNCES OF WATER, STARTED 1 HR PRIOR. HAVE WATER FINISHED WITHIN 10 MIN. DO NOT USE THE RESTROOM AFTER DRINKING.
PREGNANCY	32 OUNCES OF WATER, STARTED 1 HR PRIOR. HAVE WATER FINISHED WITHIN 10 MIN. DO NOT USE THE RESTROOM AFTER DRINKING
RENAL	NOTHING TO EAT OR DRINK AFTER MIDNIGHT, THEN 20 OUNCES OF WATER 1 HR PRIOR TO EXAM. DO NOT USE THE RESTROOM AFTER DRINKING.
RETROPERITONEAL	NOTHING TO EAT OR DRINK AFTER MIDNIGHT, THEN 20 OUNCES OF WATER 1 HR PRIOR TO EXAM. DO NOT USE THE RESTROOM AFTER DRINKING.
TRANSVAGINAL	NO PREP, BUT DO NOT LET THEM EMPTY WHAT THEY DO HAVE IN THEIR BLADDER.



Patient Name: _____ Date: _____

Feel free to ask any questions you may have at the time of your exam.

Try to be specific and use as many dates as you can.

Date Symptoms started or Date of incident:

Symptoms &/or Change in symptoms:

Recent Treatments/Medications used? Are they relieving your symptoms?

Past Injuries to Area:

Do You Have a History of Cancer?

Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? Yes No

If yes, please indicate the date and type of surgery:

Date: _____ Type of Surgery: _____
Mo. Day Yr.

Date: _____ Type of Surgery: _____
Mo. Day Yr.

Do you have a follow up appointment scheduled with your doctor?

Yes No

If yes, Date: _____ Time: _____



Patient Signature Form

Verification of Document Receipt
Privacy Notice and
Patients Rights and Responsibilities

I have been given the opportunity to read a copy of the "Privacy Notice" and "Patient Rights and Responsibilities." I understand that if I have any questions regarding these documents I may call NORTH STAR DIAGNOSTIC IMAGING at 214-618-3420 or 972-954-8001 for additional explanation.

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

Assignment of Insurance Benefits and Release of Information for Billing Purposes

I, the undersigned, have insurance coverage with _____ and assign directly to NORTH STAR DIAGNOSTIC IMAGING, SOUTHWEST IMAGING AND INTERVENTIONAL SPECIALIST AND/OR NORTH TEXAS RADIOLOGY all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

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

Patient Request of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted at the following number: _____

Please circle all that apply:

OK to leave message with detailed information

Leave message with call-back number only

Signature: _____ **Date:** _____

NORTH STAR STAFF SIGNATURE: _____ **Date:** _____