CereScan®

EXAM: Quantitative Single Photon Emission Computed Tomography (qSPECT)

Patient Name (Last):		**Patient Name (First):**	
Phone:		**Email:**	
Mailing Address:			
City:	**State:**		**Zip:**
Date of Birth:	**Age:**		**Marital Status:**
Sex: Male ☐ Female ☐	**Weight:**	lbs.	**Height:**

Responsible Party if patient is a dependent:

Name: _____ **Phone:** _____

Emergency Contact (spouse, friend, or relative who can be reached in case of emergency):

Full Name:	**Relationship to Patient:**
Phone:	**Address:**

Personal Health Information about me may be communicated with the following people:

Full Name:	**Relationship to Patient:**

If you are working with an attorney and would like us to disclose your results to them, please list their name above.

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 communication 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 in the following manner (if different from above):

☐ Phone: _____ ☐ Email:_____

The Privacy Rule generally requires healthcare providers to take responsible steps to limit the use or disclosure of and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. **NOTE: Uses and disclosures for the Privacy Officer may be permitted without prior consent in an emergency.**

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Patient Name:
Birth Date:

Insurance Information:

Insurance Carrier: _____ **Policy Number:** _____

Phone Number of Insurance Carrier: _____

Name of Primary Insured: _____ **Date of Birth of Primary Insured:** _____

Address of Primary Insured (if different): _____

Patient Treatment Information:

Please describe the treatment interventions you underwent since the time of your previous scan. Please also list any other major life changes you have encountered since your previous scan:

History of Possible Brain Injury:

Have you had any additional head traumas or brain injuries since the time of your last scan? Impact injuries to the head:

1. _____

☐ with head impact	☐ loss of consciousness	☐ post-injury confusion or headaches
☐ without head impact	☐ Amnesia/disorientation	☐ concussion

2. _____

☐ with head impact	☐ loss of consciousness	☐ post-injury confusion or headaches
☐ without head impact	☐ Amnesia/disorientation	☐ concussion

3. _____

☐ with head impact	☐ loss of consciousness	☐ post-injury confusion or headaches
☐ without head impact	☐ Amnesia/disorientation	☐ concussion

Surgical and Hospitalization History

Please list all the major surgeries and hospitalizations you have had since your last scan:

Operation/Hospitalization:	**Date:**

Brain Imaging/Testing History

Have you had any additional imaging/testing of your **brain or head** since your last SPECT scan?

Trauma or Abuse History (please check any abuse that occurred since your last scan):

☐ None ☐ Emotional abuse ☐ Physical abuse ☐ Sexual abuse ☐ Other major traumas

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Patient Name:
Birth Date:

Alcohol and Substance Use/Abuse:

Current use of alcohol (average number of drinks per week): _____

Do you use recreational drugs? ☐ Yes ☐ No If yes, what is your drug of choice: _____

Current caffeine consumption: _____ Current tobacco consumption: _____

Symptoms Checklist:

Please check any of the following symptoms you have. Please also provide a value from 1-10 describing the intensity of each symptom (10=very severe, 1=very minor):

- ☐ Anger management problems
- ☐ Balance problems
- ☐ Blurred or double vision
- ☐ Cognitive decline or changes
- ☐ Cognitive function problems
- ☐ Compulsive behavior
- ☐ Confusion
- ☐ Decreased judgment
- ☐ Delusions
- ☐ Difficulty following instructions
- ☐ Difficulty integrating information
- ☐ Difficulty learning new things
- ☐ Difficulty performing familiar tasks
- ☐ Difficulty with concentration
- ☐ Disorganization
- ☐ Disorientation to time and/or place
- ☐ Distractibility
- ☐ Elevated mood
- ☐ Excessive sadness
- ☐ Fainting spells
- ☐ Fatigue
- ☐ Flashbacks of trauma
- ☐ Frequent dizziness
- ☐ Frequent headaches
- ☐ Gastrointestinal problems
- ☐ General anxiety
- ☐ Grief
- ☐ Hallucinations
- ☐ Hot flashes
- ☐ Impulse control problems
- ☐ Inappropriate guilt
- ☐ Increased appetite
- ☐ Increased energy
- ☐ Insomnia
- ☐ Involuntary tics/tremors
- ☐ Irritability
- ☐ Long-term memory problems
- ☐ Losing things
- ☐ Loss of appetite
- ☐ Loss of interest in things
- ☐ Loss of motivation
- ☐ Low frustration tolerance
- ☐ Making careless mistakes
- ☐ Mood swings
- ☐ Muscle pain
- ☐ Muscle spasms
- ☐ Nausea
- ☐ Need less sleep
- ☐ Nightmares
- ☐ Obsessive thoughts
- ☐ Panic attacks
- ☐ Paranoia
- ☐ Performance anxiety
- ☐ Personality changes
- ☐ Problems paying attention
- ☐ Problems with abstract thinking
- ☐ Problems with language/word finding
- ☐ Promiscuity
- ☐ Psychotic episodes
- ☐ Racing thoughts
- ☐ Restlessness/Fidgetiness
- ☐ Ringing in ears
- ☐ Risky behavior
- ☐ Self-mutilation (cutting)
- ☐ Sensitivity to light
- ☐ Sensitivity to sound
- ☐ Sensitivity to touch
- ☐ Short-term memory problems
- ☐ Sleeping too much
- ☐ Social anxiety
- ☐ Suicidal thoughts
- ☐ Suicide attempt(s)
- ☐ Suicide plans
- ☐ Talkativeness
- ☐ Worry

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Patient Name:
Birth Date:

Please list any additional improvements in your life since your last SPECT scan:

Please list any additional symptoms that have WORSENED since your previous SPECT scan:

Please list current medications and supplements you are taking:

Medication/Supplement Name:	Dose:	Schedule:	Effectiveness:

Other/Notes:

Authorization:

I hereby authorize CereScan to release to my Referring Physician a copy of my medical records. I understand and agree that all images and medical records generated for and on my behalf will become part of CereScan's expanding proprietary database for ongoing scientific research into neurological and neurobehavioral disorders. I hereby authorize CereScan to use and replicate all medical information contained in the images and reports for proprietary research, training, teaching or other purposes deemed appropriate by CereScan. In order to protect my identity, I understand that all identifying information will be removed from all images and reports prior to its use.

Name:

Signature:

Date:

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Patient Name:
Birth Date:

CURRENT MEDICATIONS AND/OR SUPPLEMENTS:

Please list CURRENT medications and/or supplements. Include medication name, dose (mg), schedule (when you take them) and date you started taking them.

Medication/Supplement Name	Dose	Schedule	Date Started

ALLERGIES AND ADVERSE REACTIONS TO MEDICATIONS:

Allergen	Type of Adverse Reaction/Symptoms

I hereby authorize CereScan to release to my Referring Physician a copy of my medical records. I understand and agree that all images and medical records generated for and on my behalf will become part of CereScan's expanding proprietary database for ongoing scientific research into neurological and neurobehavioral disorders. I hereby authorize CereScan to use and replicate all medical information contained in the images and reports for proprietary research, training, teaching or other purposes deemed appropriate by CereScan. In order to protect my identity, I understand that all identifying information will be removed from all images and reports prior to its use.

_____

Signature

_____

Name (printed)

_____

Date

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Patient Name:
Birth Date:

CANCELLATION/MISSED APPOINTMENT FEE AGREEMENT

This Cancellation/Missed Appointment Fee Agreement ("Agreement") is made and entered into by and between CereHealth Corp. ("CereScan"), whose address is 991 Southpark Drive, Suite 200, Littleton, CO 80120, and _____ ("Responsible Party"), whose address is _____.

Responsible Party understands that he/she has scheduled an appointment with CereScan to obtain certain medical services. Responsible Party understands that CereScan will be required to make certain arrangements and purchase certain medical goods to prepare for his/her appointment, in advance of the visit. Responsible Party further understands that if he/she cancels or misses his/her appointment(s) or fails to comply with the stated imaging protocol, CereScan may incur costs that cannot be recovered.

In consideration of the medical imaging services to be performed by CereScan, Responsible Party agrees to pay twelve hundred ($1,200.00) dollars ("Missed Appointment Fee") to CereScan if he/she cancels or misses any of the appointments or fails to comply with the stated imaging protocol, for any reason or no reason. **Responsible Party understands that he/she may cancel or reschedule appointment(s) by calling 866-722-4806 at least forty-eight (48) hours before his/her schedule appointment(s), without being charged the Missed Appointment Fee.**

By signing this Agreement, Responsible Party understands the full amount of the Missed Appointment Fee that may be owed to CereScan, and accepts the terms and conditions of this Agreement. In the event that there are any problems with payment of the Missed Appointment Fee, Responsible Party understands that he/she may be subject to any fees incurred in collecting the account balance including, but not limited to, collection costs and legal fees.

_____

Signature

_____

Name (printed)

_____

Date