My physician has referred me for **a(n)** ______________________. I understand that the practice of medicine is not an exact science and no guarantee can be made as to the results that might be obtained from this procedure.

I understand complications can occur. By consenting to this exam, I hereby consent to the necessary medical or surgical actions of the physician and/or colleagues, medical/surgical; whomever they choose to consult with to take appropriate actions in regard to this procedure should any complications occur during my visit.

I understand that Women's Imaging Centre may include consent at satellite offices under common ownership.

I understand that this center is a member of the HCA Breast Cancer Network (BCN). If the results of my breast study are clinically positive, I understand that my contact information will be provided to the BCN Nurse Navigator so that she may immediately coordinate with me additional services as needed to determine final diagnosis. **Patient Initials: _________**

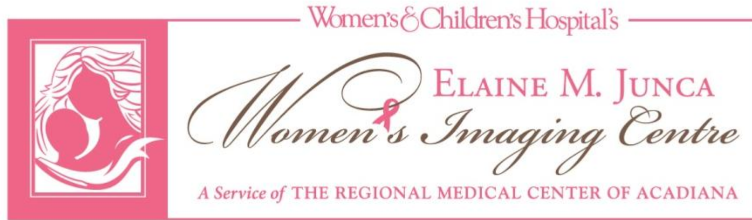
I, the undersigned, authorize Women's Imaging Centre to use and disclose my information for the purpose of treatment, payment and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

Patient Financial Responsibility: I understand my financial responsibility and I guarantee payment for all charges not covered by my insurance, all applied deductibles and co-pays, within 30 days of receiving a statement.

Medicare Patients: I authorize Women's Imaging Centre to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Women's Imaging Centre.

I acknowledge that I have been given the Women's Imaging Centre Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.
Patient Initials: _________



Over the past two weeks I have experienced the following symptoms: (check any that apply)

_____ Shortness of Breath / Difficulty Breathing

_____ Fever Greater Than 100.4

_____ Night Sweats

_____ Hoarseness

_____ Chest Pain

_____ Sore Throat

_____ Persistent Cough

_____ Persistent Cough Lasting Longer Than 3 Weeks

_____ Cough With Blood Produced

Within the past two weeks, have you: (check any that appy)

_____ Traveled Outside the U.S.

_____ Had Close Contact With a Person Who Has Avian Flu

_____ Had Close Contact With Any Person Who Has an Influenza-like Illness

_____ Had Occupational Exposure to Any Person Having an Influenza-like Illness

_____ Had Close Contact With Any Person Who Has TB or Other Respiratory Symptoms

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________ ______________________________
PATIENT OR AUTHORIZED SIGNER RELATIONSHIP

______________________________ ______________________________
PATIENT OR AUTHORIZED SIGNER RELATIONSHIP

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