

HEART CHECK WASHINGTON, D.C.
PATIENT CONSENT
ELECTRON BEAM SCAN

Date: _____ Time: _____ MR# _____

Provider: HEART CHECK AMERICA, INC., ARLINGTON HEIGHTS, IL

I hereby authorize Provider to perform upon me the following Electron Beam CT Scan(s), which are performed for the indicated purpose(s):

- _____ Coronary Scan - to detect calcification in my coronary arteries
- _____ Lung Scan - to detect abnormalities in my lungs
- _____ Abdomen/Pelvis Scan - to detect abnormalities in my abdomen/pelvis
- _____ Bone Density Scan - to measure the density of my lumbar spine
- _____ Colon Scan - to detect abnormalities in my colon

Furthermore, I understand that:

- (1) Although additional anatomic structures may be visualized, the primary focus of each scan will be the specified region(s) of interest.
- (2) During the course of this/these procedure(s) I will be exposed to radiation, and therefore assert I am not pregnant.
- (3) The indicated procedures are performed for screening purposes, and are intended to supplement, and not replace a physical exam and other screening and diagnostic procedures recommended by my physician, or which may be generally considered to be age and gender appropriate for me. Accordingly, results should be reviewed by my physician, who may order further testing and/or diagnostic procedures to further evaluate the findings or my clinical condition. Such further testing and/or diagnostic procedures may entail additional costs for which I will be responsible. I assume the responsibility of consulting with my physician regarding my test results.
- (4) Screening procedures should not be performed for the evaluation of clinical symptoms unless recommended by my physician and are not generally considered adequate to evaluate the extent or detect spread of diagnosed malignancy.
- (5) Medicare will not reimburse for this/these test(s) and no assignment of Medicare benefits will be taken. Furthermore, it is unlikely that a secondary or supplemental insurance carrier will reimburse if Medicare does not.
- (6) Heart Check Washington, D.C. does not accept assignment of insurance claims, and takes no responsibility nor makes any representations regarding insurance reimbursement.
- (7) If I ever experience chest pain, abdominal pain, pelvic pain, back pain, dizziness or shortness of breath, I should seek medical attention promptly, regardless of the results of this/these test(s).
- (8) The information provided by me and my test results will be treated as privileged and confidential in accordance with Heart Check Washington, D.C.'s *Notice of Privacy Practices*, as required under the Health Insurance Portability and Accountability Act (HIPAA). A written copy of this notice is available for my inspection upon request.

I believe I have sufficient information to provide this informed consent. I certify this form is clear to me and that I have read it, or had it read to me, that I understand its contents, and have been given an opportunity to ask questions about this consent and the indicated procedure(s).

Patient Name (please print): _____

Signature of Patient: _____