



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.

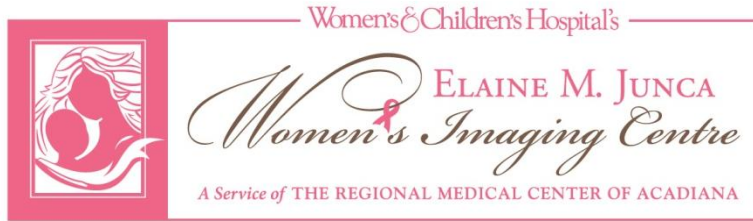
A photocopy of this consent shall be considered as valid as the original.

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 apply)

- 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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