assuredimaging
Heart Health Screenings

Assured Imaging Women's Wellness of Southern Arizona, LLC
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Official Use Only:

MR#:	*DOS:*	*EVENT:*	*Tech Initials:*

☐ *Cash* ☐ *Check #:* _____ ☐ *Debit* ☐ *Visa* ☐ *MC* ☐ *Am-Ex* ☐ *Other:* _____ *Card Holder Name:* _____

Total Amount Paid: _____

Patient Portion: _____

Employer Portion: _____

Account #: _____ *Exp Date:* _____ *Verification Code:* _____
(3 digits on back of card/ AmEx 4 digits in front of card)

Card Holder Billing Address if different than below: _____

(Please print in blue or black ink)

PATIENT INFORMATION:

Patient Name:_____ DOB:_____ Home Phone: ( ) _____

Mailing Address:_____ Apt #:_____ City:_____ State:_____ Zip:_____

Email address:_____

PHYSICIAN INFORMATION: *(Please list your primary care physician; you may request to have the report sent to more than one doctor.)*

Doctor's Name:	Doctor's Phone:	Doctor's Fax:
Doctor's Address:		Suite # :
City:	State:	Zip:

RELEASE INFORMATION AND SIGNATURES AND ACKNOWLEDGEMENT OF PATIENT RIGHTS AND PRIVACY PRACTICES:

I, _____ hereby consent to the performance of a Heart Health Screening at:
Please print patient first and last name

Assured Imaging Women's Wellness of Southern AZ, LLC. and if requested, give my permission to release my medical records:

☒ To Assured Imaging Women's Wellness of Southern Arizona, LLC.
and / or
☒ From Assured Imaging Women's Wellness of Southern Arizona, LLC.

ACKNOWLEDGEMENTS:

I acknowledge that I have received written copy of my Patient Rights and Privacy Practices from Assured Imaging Women's Wellness prior to the rendering of any services. I also understand the copies of my medical records may be mailed or faxed. I release Assured Imaging Women's Wellness from all liability for the handling of my medical records I understand that Assured Imaging's Sonographer performs the ultrasound scan and notes any findings outside of normal limits. Measurements (if applicable) will be taken and noted in a report. I understand I will receive a hard copy at the time of screening and a report will be mailed to my PCP. Assured Imaging encourages me to follow up with my health care provider. I have been informed Assured Imaging's sonographers do not have the authority to diagnose and that is why I am given the option to have my scan read by Assured Imaging's licensed radiologist. The final report will go right to my health care provider for follow up and/or treatment. The fee to have my ultrasound scan sent and read by an Assured Imaging licensed radiologist is $40.00

X _____ Date: _____ _____ Date: _____
Patient/Parent/Legal Guardian Signature Witness Signature

In the event that you (the patient) request, a copy of your report and are unable to pick them up, please list 2 people that you authorize to do that for you:

_____ _____
1ST Person (print name) 2nd Person (print name)