Emergency Responders Health Center

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Patient Consent Form

Diagnostic Ultrasound Imaging Services

PATIENT INFORMATION

Patient Full Name *Date of Birth*

Acc No.

1. PURPOSE

This consent form is intended to ensure that patients at Emergency Responders Health Center (ERHC) are fully informed of the scope, benefits, limitations, and financial responsibilities associated with diagnostic ultrasound imaging services prior to receiving care.

Please read each section carefully. Should any questions arise regarding your ultrasound imaging services, a member of ERHC's clinical team is available to assist prior to signing.

2. ABOUT DIAGNOSTIC ULTRASOUND IMAGING

Diagnostic ultrasound uses high-frequency sound waves to evaluate a specific symptom, condition, or finding identified by a medical provider. Unlike a screening exam, a diagnostic ultrasound is ordered to investigate a particular clinical concern. Exams are performed by a registered diagnostic, vascular, or echocardiography sonographer, depending on the type of study ordered, and are interpreted by a board-certified Radiologist or Cardiologist within their respective specialties.

3. BENEFITS, RISKS, LIMITATIONS & RESULTS

Ultrasound imaging is a safe, non-invasive procedure using high-frequency sound waves. As with any diagnostic test, there are both benefits and limitations I should understand before receiving ultrasound imaging services.

POTENTIAL BENEFITS

- Helps identify the cause of my symptoms or confirm/rule out a suspected condition
- Real-time, point-of-care imaging supports faster, more informed clinical decisions
- Guides my provider's recommendations for treatment or further evaluation

POTENTIAL RISKS & LIMITATIONS

- **Discomfort during the exam:** Mild, temporary discomfort or pressure from the transducer, positioning, or a full bladder.
- **Gel reaction:** Possible allergic or skin reaction to the ultrasound gel.
- **False positives:** May flag an insignificant or benign abnormality, possibly causing stress or anxiety.
- **False negatives:** A normal result does not guarantee the absence of disease.
- **Image/interpretive limitations:** Body size, shape, or positioning may reduce image quality.
- **Additional evaluation costs:** Follow-up testing may create out-of-pocket costs depending on my insurance plan.

Important Note: A Finding Is Not a Diagnosis

A finding on ultrasound imaging is not a diagnosis. My medical provider will discuss the clinical significance of any concern and recommend appropriate next steps.

Results & Follow-up

Results are typically uploaded to the ERHC patient portal (eClinicalWorks) within roughly 1-3 days, though timing can vary. I will review my results with my ordering provider at a scheduled follow-up appointment. Depending on findings, additional testing or follow-up care may be recommended, and any associated out-of-pocket costs may be my responsibility.

4. PATIENT FINANCIAL RESPONSIBILITY

Diagnostic ultrasound imaging is billed through my personal health insurance. I will be responsible for any deductible, co-pay, coinsurance, or costs not covered by my insurance plan.

If a finding on my diagnostic ultrasound leads to a recommendation for further evaluation, testing, or specialist referral, those services will also be billed through my insurance, and any remaining balance is my responsibility.

5. PATIENT RIGHTS

I have the right to ask questions at any time before, during, or after my ultrasound exam, and to receive a copy of this signed form for my records. I may discuss my results with my provider, seek a second opinion, and request access to my health information, including ultrasound images, in accordance with HIPAA regulations, at any time.

6. ACKNOWLEDGEMENT & PATIENT SIGNATURE

By signing below, I confirm that I have read and understood the information contained in this consent form, and I have had the opportunity to ask questions.

I understand the scope, purpose, benefits, limitations, and risks of the diagnostic ultrasound imaging exam(s) that I am about to receive.

I understand that these services will be billed through my personal health insurance, and I am responsible for any applicable deductible, co-pay, or coinsurance (Section 4).

I understand that any additional testing, evaluation, or treatment recommended as a result of an abnormal finding is not covered under this consent and may create additional out-of-pocket costs.

Patient Signature	*Date*