Buford Road Imaging
HCA Virginia Health System
An HCA affiliate

Patient Consent Form

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 **Buford Road Imaging** may include consent at satellite offices under common ownership.

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

I, the undersigned, authorize **Buford Road Imaging** to use and disclose my information for the purposes 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 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 **Buford Road Imaging.**

☐ I acknowledge that I have been given the **Buford Road Imaging** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

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Patient Identification Sticker Here

Please indicate if you have had:

YES No Persistent Cough lasting longer than 3 weeks

If YES, please answer the following:

YES No Fever greater than 100 F
YES No Night Sweats
YES No Cough with blood production
YES No Unexplained weight loss
YES No Fatigue
YES No Prior history of Tuberculosis or positive skin test for TB
YES No Close contact with anyone who has Tuberculosis

In the last seven (7) days, please indicate if you have had:

YES No Fever greater than 100 F

If YES, please answer the following:

YES No Sore throat
YES No Cough not related to allergy or COPD
YES No Body Aches
YES No Rash
YES No Nasal Congestion not related to allergies or sinus infection
YES No Close contact with any person having influenza-like illness

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

_____ _____

Patient** (or person authorized to consent for the patient)* ***Relationship

_____ _____

Witness ***Date/Time***

Staff Use Only:		
Mask Applied	Y	N
Receiving Dept Notified	Y	N

Patient Identification Sticker Here