LifeScreen Imaging, PLLC

Consent, Release and Waiver of Liability

The undersigned (a Client of Life Screen Imaging) has read and agrees to the following:

I. Screening Acknowledgement

a. I understand that CT, though a sensitive exam for detection of certain diseases and conditions, is not perfect. Tumors may be too small to detect at the time of my examination. “Benign” conditions may be discovered that could require further evaluation, including biopsies. Features that appear to be lesions may be identified, and these may require additional work-up, including additional diagnostic tests, to verify. There are diseases and conditions that CT cannot detect. LifeScreen’s whole body CT scan does not include a scan of the head. LifeScreen does not use contrast agents in its scans because of the potential adverse side effects that those agents may cause. A scan with contrast may identify diseases and conditions that a scan without contrast may not identify. Scans that are done with contrast can be done at Seattle Radiologists, but a physician’s referral would be needed.

b. CT colonography “colonoscopy” is used to detect polyps or cancers. CT does not effectively screen for other conditions of the colon/intestine.

c. Cardiac CT detects calcium in coronary artery plaques. This information is quantitative and may be of use in determining your risk of having a heart attack. A normal exam, however, does not mean I am risk free or that I do not have heart or vascular disease or a related condition. This CT exam does not replace a thorough cardiac examination but may be of use to your physician in planning your overall care.

d. If I am currently experiencing symptoms, I may not be eligible for this exam. Ct screening does not replace a thorough examination by your physician. By initialing below, I acknowledge this.

e. I understand that the screening services that I am receiving from LifeScreen do not replace the need for me to have an annual physical examination with my primary care physician, to secure appropriate preventative health care (including, but not limited to, routine periodic fecal occult blood tests, blood cholesterol and lipid profiles, CBC, renal chemistry tests sigmoidoscopy, colonoscopy, ECG, chest x-ray, and other services that may be necessary based on my personal, family, social and medical history), and to receive other health care services.

Patient Initials: __________

II. Clinical Studies

a. Lifescreen imaging and Seattle Radiologists, APC are actively involved in research regarding the utility of screening Ct exams. By initialing below, I authorize the use of my exam results in this research so long as it is done without identifying me by name. Seattle Radiologists, APC will provide the interpretations of the studies by Lifescreens.

Patient Initials: _______

III. Pre-existing conditions

a. I acknowledge that based on my medical history it has been determined that the exam today is not a covered service. I have provided true, correct and complete history information to LifeScreen. If at any time during the intake process it is determined that I have a pre-existing condition that is covered by a third party, LifeScreen Imaging will refuse service to me and will need to refer me back to my health care provider.

Patient Initials: _______

IV. Transfer of Care

a. I understand that if the screening exam identifies a finding that requires follow up care it is my sole responsibility to pursue any appropriate and necessary care with my physician.

b. I and my heirs, executors and representatives hereby release, waive, discharge, hold harmless and indemnify LifeScreen Imaging, its agents, members, employees and directors from all liability (including and without limitation, attorney's fees and cost) arising out of any failure by me to seek follow-up consultation, care and treatment, regardless of whether the CT screening exam results are normal or abnormal.

c. I do_____/do not _____ need a referral to a primary care physician

Patient Initials: _______

V. Explanation of Medical Risk

a. There is a small risk associated with the use of medical x-rays. The risk is believed to be minimal compared to the benefit of early diagnosis of disease. I will consult with my physician if I have any questions regarding my health. I understand that women who may be pregnant should not have this exam. I will notify LifeScreen if I am not absolutely certain of my pregnancy status.

Patient Initials: _______

VI. Notification of Non-Coverage

a. I understand and agree that the CT exam(s) I receive are not eligible for Medicare or other medical insurance reimbursements and that I am solely and totally responsible for payment in full.

Patient Initials: _______

VII. Designation of Primary Care Physician

a. LifeScreen will send a copy of the written report of my scan to my primary care physician.

b. Primary Care Physician:

Name: ____

Address: ____

Phone: ____

c. LifeScreen Imaging will provide me with referral if I have not designated a primary care physician in subsection (b) above.

d. If a significant finding is identified on my clinical examination, LifeScreen will contact me and my primary care physician by telephone.

e. By signing below, I authorize LifeScreen to send a copy of the written report and telephone my primary care physician or, in the event that I have not designated a primary care physician above, a physician referred by LifeScreen, as provided in subsection ©.

Patient Initials: ________

In witness whereof, the undersigned hereby agrees to, acknowledges and accepts those provisions of this consent (i.e., Parts, I,II, III, IV, V, VI, VII), which have been initialed by the undersigned above. I have read and understand the information provided on this form and I authorize and consent to the performance of the CT screening exam(s).

LifeScreen Imaging Patient:

Print Name: ____

Signature: ____ Date: ______/______/______