PREMIERE PERINATAL ASSOCIATES, PA

CONSULTATIVE & DIAGNOSTIC CENTER FOR HIGH RISK OBSTETRICS
500 SE 17TH STREET, SUITE 100
FT. LAUDERDALE, FL 33316

SONOGRAM CONSENT FORM

Safety

As part of your evaluation here, you may have a fetal sonogram performed. To date, there are no known risks or damages to the fetus from sonography, however, we cannot predict what information may become known at a later time. To that end, we only perform fetal sonography when there is a medical indication for the test.

Limitation

New technologies have allowed us to see the fetus in impressive detail. However, it is very important to recognize that a fetus that appears to be “normal” on sonographic evaluation may in fact have birth defects, mental retardation, or other abnormalities that cannot be detected by current technology. The ability to diagnose many birth defects, particularly those involving the brain, spine, face, heart and extremities, is also limited by the gestational age at examination, the fetal position, the amount of amniotic fluid present, and may only become sonographically identifiable as the pregnancy progresses. This is especially true for the brain, heart, and gastrointestinal anomalies, and defects caused by viral infections. Chromosomal abnormalities (Down Syndrome, for example) cannot be reliably diagnosed, or ruled out, using sonography alone. An amniocentesis is necessary to do that.

This information is not meant to make you worry about your baby; most of the time if the sonogram appears to be normal, the baby does not have any birth defects. This information is simply to make you aware of the limitations of sonography to make diagnoses and that a “normal” sonogram cannot guarantee the baby will not have some abnormality. No test can do that. If you have any questions about your sonogram, please do not hesitate to ask. We will be happy to answer any questions that you may have.

Acknowledgment

I have read the above information and I understand the limitations of sonography to diagnose birth defects and other abnormalities of my baby. Also, I authorize the release of information to Premiere Perinatal Associates, PA regarding the baby and myself at the time of delivery in the form of a copy of the hospital Labor and Delivery summary sheet.

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Signature **Date**

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Consent for Treatment – By signing this consent, I am authorizing my physician(s) to perform and/or order another person to perform all exams, test, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Premiere Perinatal Associates, PA unless revoked by me orally or in writing.

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Date **Patient / Legal Representative**

Authorization for Release of Information – I understand this information will only be furnished: (1) to my insurance(s) to which my medical bills have been assigned for payment; (2) as required by law; (3) upon my written authorization on a form acceptable to Premiere Perinatal Associates, PA. I understand that my medical information will not be released to any persons other than those named without my express written permission. I also understand that with my written permission, my entire record including HIV status can be release to the healthcare providers as specified in my written request. Any revocation of this release must be submitted in writing to Premiere Perinatal Associates, PA.

For the purpose of this release "medical information" shall mean copies of all medical records, test, x-rays, reports and/or other materials in the possession of Premiere Perinatal Associates, PA relating to my medical condition and proposed or actual treatment. *I understand that by signing this consent I am also authorizing release of any information contained within the medical record which may be related to AIDSs and/or HIV antibody or Antigent testing.*

By signing this consent to Release Medical Information, I agree not to hold liable Premiere Perinatal Associates, PA, their agents and employees, (for any unfavorable outcomes as the result of releasing this information). *I realize that Release of Medical Information may be necessary before my insurer will cover the cost of my medical treatment, and that by failing to authorize the release of this information, I may be required to pay the entire bill.*

______________________ ______________________

Date **Patient / Legal Representative**

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ASSIGMENT OF INSURANCE BENEFITS – I hereby authorize payment directly to Premiere Perinatal Associates, PA of surgical or medical benefits, including major medical, but not to exceed regular charges for these services. I understand that I am financially responsible for charges not covered by my insurance.

MEDICARE – MEDICAID – I certify that the information given by me in applying for payment under title XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers.

Any information needed by this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

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Date | Signature of Patient or Legal Representative

If legal representative, please indicate the relationship to patient: (e.g., Parent, Family Member, Spouse, Guardian, Close relative or Guarantor):

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