HAVEN HEALTH

CONSENT FOR ELECTIVE ENTERTAINMENT ULTRASOUND

Client Name: _____ Date of Birth: _____

Phone Number: _____ Email: _____

I hereby authorize Haven Health Clinic of Rome, Inc. to perform an ultrasound on my baby and me. I elect to have the ultrasound and I understand that its purpose is *NOT* diagnostic in nature. I understand that the ultrasound is for entertainment only and is *NOT* intended to detect obstetrical problems or fetal birth defects and should not replace prenatal care. I understand that if I suspect that I have a medical disease or condition that needs diagnosis, I should see a physician. I fully understand that this procedure is for the purpose of obtaining a two-dimensional view of my baby. I understand that these services are not covered by insurance providers.

I understand that there is no physician on site at Haven Health Clinic of Rome and that Entertainment ultrasounds will not be reviewed by a physician. No formal medical record will be recorded and no physician will interpret the findings. If I am given an ultrasound picture of my baby, I understand that it is for my own personal use and any interpretation of those pictures is my own.

Ultrasound is a medical procedure that uses high-frequency sound waves to produce images of the human body. Ultrasound procedures do not involve exposure to any X-ray or other radioactive substances.

I hereby state that I understand and have been advised that the above-described activities will require physical contact with my body and may require contact with intimate parts of my body. I understand that, in the event I feel uncomfortable with such contact, I can inform the staff member performing or facilitating a certain activity of such discomfort in an effort to lessen such discomfort, if possible. I hereby consent to the touching reasonably contemplated by this agreement.

I recognize that there are certain inherent risks associated with the above-described procedure and I assume full responsibility for personal injury to myself. As partial but required consideration for such procedure, I hereby fully release and forever discharge the technician (including its officers, members, owners, employees and agents) from any and all damages, costs, expenses, liabilities, causes of action, claims and demands, of whatever character, in law or in equity, whether known or unknown, direct or indirect, asserted or unasserted, and whether or not on account of myself, the technician, or other third parties, or in any way arising out of the above-described procedure I have requested the technician perform. It is the intention of the parties that this agreement binds all parties whose claims may arise out of or relate to the procedure or services provided by the technician including any spouse or heirs of the client/patient and any children, whether born or unborn.

Haven Health Clinic has my permission to communicate with my OB provider _____

if necessary. I further understand that a HIPAA Release may be necessary for complete communication with such provider, and, if such a release proves reasonably necessary, I may be contacted.

I acknowledge that during this appointment, an optimal view of my baby may not be available due to the baby's position or the amount of amniotic fluid present. I recognize this as a risk inherent to the procedure and understand my money will not be refunded in such an event.

I hereby acknowledge that I have read and understand the information in this document.

Client Signature: _____ Date: _____