Southwest Medical Thermal Imaging & Ultrasound, LLC

Informed Consent for Ultrasound / Sonogram

Patient Name: ______________________________________ DOB: _____________

You have requested that we perform an ultrasound/sonogram (US) to obtain additional information. This is a diagnostic test that uses sound waves and a computer to produce images of internal body parts.

The benefit of this exam is to assist your physician with making a diagnosis.

By my signature below, I hereby certify that I have fully read this consent, had it explained to me or have had it read to. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

____Date: ________________
Patient/ Parent/ Legal Guardian Signature

____ Date: ________________
Southwest Medical Thermal Imaging & Ultrasound, LLC

Authorization to Use or Disclose Protected Health Information
Southwest Medical Thermal Imaging & Ultrasound, LLC

Patient Name:____

Address: ____

Date of Birth: ______________________ Date of Request:_______________

As required by the Privacy Regulations, Southwest Medical Thermal Imaging & Ultrasound, LLC may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

Thomas Hudson, MD PA

Patient Health Information authorized to be disclosed: **Ultrasound Images, Thermography Reports and related health history**
____

For the specific purpose of (describe in detail)
Interpretation of said images

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____
This authorization will expire at the end of the above period.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

____ _____________
Signature or Patient or Patient's Authorized Representative *Date*

____ ___________________
Authorized Signature of Facility *Date*

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Southwest Medical Thermal Imaging & Ultrasound, LLC

REQUEST FOR ALTERNATIVE COMMUNICATIONS

Patient Name:____
Address: ____
Date of Birth: ____________________ Date of Request:______________

As allowed by the Privacy Regulations, I wish for this office to provide the following "Alternative" means of communicating my Protected Health Information:

☐ **Mailing Address**.
If appropriate, please contact me at the following address:
____

☐ **Phone.**
If appropriate, please contact me by telephone at the following number:
____

☐ **Fax.**
If appropriate, please contact me by fax at the following number:
____

☐ **E-Mail.**
If appropriate, please contact me by E-mail at the following E-mail address:
____

☐ **I have the following additional requests for confidential communications regarding my Protected Health Information:**
(Please explain. For example if requesting records be sent to healthcare provider give name and mailing address)

____

____

I understand that there may be additional costs associated with this request and I agree to reimburse this office for such costs.

____________________________________ ________________
Signature Date

☐ Accepted as requested. ☐ Modified as noted: ______________

____________________________________ ________________
Authorized Signature of Facility Date

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Southwest Medical Thermal Imaging& Ultrasound, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Southwest Medical Thermal Imaging & Ultrasound, LLC is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Southwest Medical Thermal Imaging & Ultrasound, LLC."*
>
> *"It is our policy to provide a substitute health care provider, authorized by Southwest Medical Thermal Imaging & Ultrasound, LLC to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. Example:

> "*As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Southwest Medical Thermal Imaging & Ultrasound, LLC for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.

We may disclose your health information to coroners or medical examiners.

Organ Donation.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.

We may contact you for marketing purposes or fundraising purposes, as described below: Example

> *"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."*
>
> *"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.*

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We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Southwest Medical Thermal Imaging & Ultrasound, LLC sponsored fund-raising events."

Change of Ownership.
In the event that Southwest Medical Thermal Imaging & Ultrasound, LLC is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Southwest Medical Thermal Imaging & Ultrasound, LLC is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Southwest Medical Thermal Imaging & Ultrasound, LLC amend your protected health information. Please be advised, however, that Southwest Medical Thermal Imaging & Ultrasound, LLC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Southwest Medical Thermal Imaging & Ultrasound, LLC.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Southwest Medical Thermal Imaging & Ultrasound, LLC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Southwest Medical Thermal Imaging & Ultrasound, LLC is required by law to comply with this Notice.

Southwest Medical Thermal Imaging & Ultrasound, LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: **Taryn Kean** by calling this office at 239-949-2011. If **Taryn Kean** is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints
Complaints about your Privacy rights, or how Southwest Medical Thermal Imaging & Ultrasound, LLC has handled your health information should be directed to **Taryn Kean** by calling this office at 239-949-2011. If **Taryn Kean** is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.
If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of ______/______/_______

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Southwest Medical Thermal Imaging & Ultrasound, LLC with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

____
Patient's Name (print)

____ ______________
Patient's Signature Date

____ ______________
Authorized Facility Signature Date

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