HDI
High Desert Imaging

Patient Full Legal Name:_____

Date of Birth:_____ MR#_____

Exam Today: **CT** ☐ **MRI** ☐ **XRAY** ☐ **DEXA** ☐ **MAMMO** ☐ **US** ☐

Consent to Treatment - Outpatient

Consent For Medical Treatment: The patient named below hereby voluntarily consents to the rendering of medical care, which may include such medical treatment as the attending physician(s) or other consulting physicians consider to be necessary. I understand that I must look solely to the attending physician(s) for interpretation of the results of any diagnostic procedure or test, and medical treatment. The patient has a general understanding of the nature and purpose of his/her medical treatment and is generally aware that medical complications can occur. The patient acknowledges that no guarantees have been made as to the result of treatment. The patient consents to other health care personnel in training being present during treatment and in some instances providing supervised treatment. The patient understands that some treatments will occur in areas that may also be occupied by other patients being treated.

Patient Valuables: High Desert Imaging shall not be liable for the loss or damage to any patient personal property.

YOUR SIGNATURE BELOW ACKNOWLEDGES THAT YOU HAVE READ AND UNDERSTAND THIS DOCUMENT AND ACCEPT ITS TERMS. You are also acknowledging that you have been offered a copy of this document.

High Desert Imaging does not discriminate on the basis of age, sex, marital status, race, creed, color, national origin or the presence of any sensory, mental or physical handicap.

The patient has read this form, and is satisfied that he/she understands its content and significance.

Dated: _____

Signature of Patient Signature of Witness

_____

Patient's Agent or Representative or Guarantor Relationship to Patient

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Rev.8/22/2016