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3D Ultrasound Waiver

I _____ am seeking elective prenatal ultrasound(s) at Seasons Healthcare for Women. I understand that I must be receiving routine prenatal care with my own healthcare provider listed below. I will receive my diagnostic ultrasound to screen for fetal anomalies ordered by my physician at the location they specify.

This (these) ultrasound(s) are not intended to be diagnostic in any way. I also understand that this ultrasound will not be reviewed by a physician.

I also agree that I am the only one who will be given a copy of the pictures produced. I will receive the original CD and or DVD and a copy will not be kept on file at Seasons HealthCare for Women.

Healthcare Provider's Name: _____

Healthcare Provider's Phone: _____

Verified By: _____ Date: _____

My signature below indicates that I accept all of the above conditions. I also authorize a representative from Seasons Healthcare for Women to contact my provider prior to the initiation of my elective prenatal ultrasounds.

Signature: _____

Printed Name: _____

Date: _____