the WOMAN'S IMAGING group

Self Referral Acknowledgement

I,_____, am requesting a screening mammogram at The Woman's Imaging Group. I am not under the care of a primary care health provider. I accept full responsibility for my care.

I understand that:

_____ 1. I will receive a copy of the health care provider report. I am responsible for providing this report to a health care provider for future care.

_____2. I will receive a letter explaining the results of my screening mammogram.

_____3. I will accept full responsibility for selecting a health care provider in the event that the findings of my mammogram warrant further medical attention.

_____4. I understand that a representative of The Woman's Imaging Group may offer suggestions for a health care provider, but I am under no obligation to select a provider recommended by the facility.

_____5. I will accept full responsibility for seeking the proper health care, should it be recommended by the interpreting physician.

_____6. I will not hold any personnel of The Woman's Imaging Group, including technologists and/or radiologists, responsible or liable for future care, should it be recommended by the interpreting radiologist.

_____ Patient Name

_____ Witness Name

_____ Patient Signature

_____ Witness Signature

_____ Date

_____ Date