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CONSENT FORM FOR ELECTIVE ULTRASOUND

I hereby authorize WeeBaby Imaging, LLC to perform an elective, limited 2D, 3D, and/or 4D ultrasound on me and my baby. I elect to have this procedure and I understand that this ultrasound is not intended to take the place of a full diagnostic ultrasound or any other test or treatment that has been recommended by my healthcare provider. I am aware that the purpose of this ultrasound is not to detect obstetrical problems or fetal abnormalities. I fully understand that this procedure is only used for the following purposes: to obtain a three dimensional view of my baby in the womb, to view my baby in 3D imaging with real time (4D), or to obtain 2D images of my baby in the womb and/or to reveal my baby's gender. I agree that these services are not covered by insurance and will be paid for at the time of service. I have been seen by a physician and have had a routine clinical appointment with my physician. I have documentation of his/her authorization for me to have an elective ultrasound at WeeBaby Imaging, LLC.

I understand that during this ultrasound, an optimal view of my baby may or may not be available due to the baby's current position in the womb or the amount of amniotic fluid present. In this case, I understand that I may be asked to return for another ultrasound at a different time than scheduled at no additional charge.

I hereby acknowledge that I have read and understand the information in this document and that through my signature, I agree to all of the terms stated.

Patient Signature: _____

Patient Name (printed): _____

Date of Birth: _____