Lifecare Primary Medical Associates, PLLC

633 E Fernhurst Dr. Suite 202. Katy, TX-77450, Tel: 281-712-7757, Fax: 281-712-7758

CONSENT FOR RENAL ULTRASOUND

In order to determine an appropriate plan of medical management,

I_____, herby consent to:

This ultrasound procedure can detect cysts, tumors, abscesses, obstructions, fluid collection, and infection within or around the kidneys. This procedure may also be used to determine blood flow to the kidneys through the renal arteries and veins.

Risks: There are no risks specifically associated with this procedure.

Patient Name (Please Print)	DOB
Patient or Guardian Signature	Date
Nurse	Witness Signature

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Patient Registration Form

Patient's Name	Age	Sex	Birthdate
☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated			
Social Security No.	Home Phone No.	Cell Phone No.	
Home Address			
City	State	Zip	Email
Patient Employed By		Occupation	
Business Address	City / State / Zip		Business Phone ( )
Name of Spouse		Social Security No.	
Referred By: ☐ Physician ☐ Hospital ☐ Others: (Please Specify)			
If Patient is a Minor; Name of Responsible Parent		Pharmacy Name & Phone No.	
EMERGENCY Person to Contact		EMERGENCY Home Phone No. & Cell No.	

CONTACT CONSENT

I _____(Patients Name) give **Lifecare Primary Medical Associates, PLLC, Staff** authorization to release my personal and confidential information to:

Name:_____ Relation: _____ Phone No. _____
Name:_____ Relation: _____ Phone No. _____
Name:_____ Relation: _____ Phone No. _____

INSURANCE INFORMATION

Name, Address, & Phone No. of **Primary Insurance**:

Name, Address, & Phone No. of **Secondary Insurance**:

Name of Insured If The Responsible Party is Not The Insured & Relationship to Patient:

AUTHORIZATION TO PAY PROVIDER & MEDICAL RELEASE

I herby authorize Lifecare Primary Medical Associates, PLLC and affiliated or other providers to release any information acquitted in the courses of my treatment to my insurance company, employer, or third-party payer as enquired for claims filed, quality assurance, health plan administration, complaints/grievances. I understand that the specific information to be released may include, but is not limited to history, diagnosis and/or treatment of drug or alcohol abuse, mental/psychiatric related illness or communicable disease, including Human Immune-deficiency Virus (HIV) and Acquired Immune Deficiency (AIDS).

I authorized direct payment to be made to the office of **Lifecare Primary Medical Associates, PLLC** or other providers for any and all medical or surgical services rendered. I certify that the information above is true and correct to the best of my knowledge.

_____ _____

SIGNATURE AUTHORIZING the release of personal & confidential information to the **CONTACTS listed above**, to my **INSURANCE Company** (For billing purposes ONLY), & to **AUTHORIZE PAYMENT TO THE PROVIDER** Date