Mercer Health

800 West Main Street
Coldwater, Ohio 45828
Telephone: 419-678-5111
Form 396 Revised: 05/2022

Patient Label

Radiology Vascular Screening Program

Participant's Last Name	Legal Name	MI	Date of Birth	Sex
				M F

Address	City	State	Zip	Phone #

- I hereby request and grant permission to Mercer Health Radiology Department to perform certain Ultrasound screening tests as set forth below. I request and authorize Mercer Health to obtain these results and mail them to me at the above address.
- I understand that this testing should NOT be used as a means to diagnose the existence or absence of any medical condition. I understand that I alone am responsible for obtaining medical information or services from a doctor or other qualified health care provider.
- I understand that it is my responsibility to send or share this information with my personal physician. Mercer Health is not proposing diagnosis or recommending medical treatment, but merely acting as a resource to provide this additional medical information. I understand that should I become ill, have complications, or have questions regarding my health, it is my responsibility to contact my physician.
- I understand that these test results **will be included in the complete medical record** chart kept at Mercer Health and may be viewable by my health care provider.
- I am releasing all agents, employees and volunteer personnel involved in this health screening from any and all liability for the results of the testing, screening or any treatment I may receive from a physician of my choice based upon the information provided in this program.
- I understand that because these tests are a screening tool and not ordered by a physician, insurance companies routinely do not cover these tests.
- I understand that Mercer Health will NOT submit these tests for insurance reimbursement.
- I understand that some of these tests may not be completed due to body habitus or internal artifacts

I have read, understand and agree to the above provisions:

Participant signature _____ Date/Time_____

____ $45 Vascular Screening Package: all 3 screenings; carotid artery, abdominal aorta and peripheral artery.

$_____ Total Due Paid: Cash _____ Check# _____ Credit Card _____ Rec'd By _____