<u>3D/4D PATIENT INFORMATION &CONSENT</u>

LAST NAME: ________________________ FIRST NAME: ________________________________

MAILING ADDRESS: ____

CITY: ______________________________ STATE: _______ ZIP CODE: _______________

PHONE: _______________________ CELL: ___________________ WORK: __________________

DATE OF BIRTH: ________________ ESTIMATED DUE DATE: ____________________________

PHYSICAN'S NAME: ________________________________ PHONE: _______________________

I agree to the following terms and have initialed each item below in acknowledgement:

_______ Treasured Memory Photos is an elective ultrasound exam.

_______ Treasured Memory Photos are for enjoyment purposes only.

_______ No measurements of the baby will be taken and anatomy will not be evaluated.

_______ I acknowledge I have had a prior 2D medical ultrasound after 17weeks gestation to determine the health of my baby.

_______ I acknowledge I am currently under the medical care of the provider indicated above for my pregnancy.

_______ I understand it is not always possible to get a 3D/4D picture and agree to pay the $50.00 Room Fee Charge if this happens.

_______ I agree to hold Fairbanks Community Imaging LLC and its physicians and employee's harmless and not liable for anything undetected or any adverse pregnancy outcome.

_______ I agree to allow Fairbanks Community Imaging LLC to use my photos for promotional uses only. FCI will delete any personal identifying information for such intended purposes.

How did you hear about us? ____

____ ______________________________

Patient Signature Date