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SONOGRAM POLICY

OUR PHYSICIANS ONLY SCHEDULE SONOGRAMS FOR OUR PATIENTS THAT THEY FEEL ARE MEDICALLY NECESSARY. ONE ROUTINE SONOGRAM WILL BE DONE AT 24 WEEKS OF PREGNANCY. MOST, IF NOT ALL INSURANCE COMPANIES PAY FOR MEDICALLY NECESSARY SONOGRAMS. HOWEVER THE OCCASION MAY ARISE WHEN A PATIENT DESIRES A SONOGRAM TO DETERMINE THE SEX OF THE BABY OR FOR OTHER REASONS THAT MAY NOT BE MEDICALLY NECESSARY. IN SUCH A CASE, THE PHYSICIAN WILL PERFORM THE SONOGRAM FOR THE PATIENT BUT WILL ASK THAT THE PATIENT PAY FOR THE PROCEDURE IN ADVANCE. THANK YOU FOR YOUR COOPERATION!!

Name: _____ Signature: _____ Date: _____

THE HIV ANTIBODY BLOOD TEST DISCLOSURE CONSENT AND RELEASE OF LIABILITY

THE PURPOSE OF THIS FORM IS TO DOCUMENT THAT I OR MY PHYSICIAN HAS REQUESTED THAT MY BLOOD BE TESTED TO DETECT WHETHER OR NOT I HAVE ANTIBODIES IN MY BLOOD TO THE HIV VIRUS, WHICH MAY BE A CAUSATIVE AGENT OF ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). I UNDERSTAND THAT THE TEST IS NEW AND ITS ACCURACY AND RELIABILITY ARE STILL UNCERTAIN AND THAT THE TEST RESULTS MAY IN SOME CASES, INDICATE THAT A PERSON HAS ANTIBODIES TO THE VIRUS WHEN THE PERSON DOES NOT (FALSE POSITIVE) OR THE TEST MAY FAIL TO DETECT THAT A PERSON HAS THE VIRUS (FALSE NEGATIVE). I ALSO UNDERSTAND THAT A POSITIVE BLOOD TEST DOES NOT MEAN THAT I HAVE AIDS. I UNDERSTAND THAT NO WARRANTY AND NO GUARANTEE HAS BEEN MADE TO ME AS TO THE RESULTS OF THIS TEST. I VOLUNTARILY REQUEST AND CONSENT TO THE ADMINISTRATION OF THE TEST. THE CONFIDENTIALITY OF MY MEDICAL RECORDS WILL BE MAINTAINED. HOWEVER, MY PHYSICIAN OR OTHER HEALTH CARE PROVIDERS, REPRESENTATIVES OF FEDERAL, STATE AND LOCAL GOVERNMENTAL AGENCIES MAY ASK TO SEE THE RESULTS FOR MEDICAL OR SCIENTIFIC REASONS OR THE RESULTS COULD BE RELEASED BY COURT ORDER. FURTHER, INSURANCE COMPANIES AND OTHER THIRD PARTY PAYORS MAY REQUEST THESE RESULTS IF REIMBURSEMENT IS REQUESTED FOR THE TEST FROM THESE THIRD PARTY SOURCES. I AGREE THAT IN THE EVENT OF A POSITIVE TEST, THIS OFFICE RESERVES THE RIGHT TO NOTIFY THE SPOUSE OF ANY INDIVIDUAL SUBJECTS TO POTENTIAL EXPOSURE. I HEREBY RELEASE DR. FONG, AGENTS, AND MEDICAL STAFF FROM RESPONSIBILITY AND CONSEQUENCES RESULTING FROM THE ADMINISTRATION OF THE TEST.

Name: _____ Signature: _____ Date: _____