Elevated Echo

3010 Santa Fe Ct, Ste 119 • Missoula, MT 59808
Phone: (406) 215-1434 • Fax: (406) 215-1743
contact@elevated-echo.com • elevated-echo.com

INFORMED CONSENT

Consent to Diagnostic Echocardiography

I consent to having an echocardiogram (ultrasound imaging of the heart) and any related diagnostic procedures ordered by my physician or provider at Elevated Echo, an independent diagnostic testing facility (IDTF).

What I Understand

- An echocardiogram uses ultrasound to create images of my heart. Gel is applied to my skin, and a probe (transducer) is placed on my chest.
- This is a non-invasive test with no known significant risks. Minor discomfort from probe pressure, or rare gel allergy, may occur.
- If a contrast agent is ordered, I will be told about any additional risks before it is used.
- A board-certified cardiologist will interpret my results and send them to my referring provider.
- Elevated Echo provides diagnostic testing only — not treatment or follow-up care.
- I have had the chance to ask questions about the procedure, its purpose, benefits, risks, and alternatives (including no testing), and my questions have been answered.

Financial Responsibility

Elevated Echo will bill my insurance (if applicable) for services provided. I authorize the release of medical information needed to process claims. I am responsible for any copays, deductibles, coinsurance, or non-covered services. If self-pay, I agree to pay at the time of service or as arranged.

Voluntary Consent

This consent is voluntary. I may refuse or withdraw it at any time without affecting my care elsewhere. It applies to today's visit and any future diagnostic tests at Elevated Echo unless I revoke it in writing.

Privacy Notice

I acknowledge that I have received a copy of Elevated Echo's Notice of Privacy Practices, which describes how my health information may be used and shared.

_____
Patient Name (printed)

_____ _____
Patient Signature (or legal representative) Date

_____
Email Address