HUDSON VALLEY RADIOLOGY ASSOCIATES

FIRST TRIMESTER SCREENING CONSENT FORM

This form explains the First Trimester Screening Program at Hudson Valley Radiology.

About First Trimester Screening

By signing this form, you are electing to receive a First Trimester Screening ("FTS"), a screening test used to assess the risk of Down Syndrome, trisomy 18, and certain other structural malformations. As a screening test, FTS does not guarantee the birth of a chromosomally normal child, and does not replace chorionic villous sampling (CVS) or amniocentesis as the definitive diagnostic test of abnormal fetal chromosomes. Regardless of first trimester screening results the American College of Obstetrics and Gynecology wants you to know that invasive diagnostic testing such as amniocentesis or CVS are medically safe options with a very small miscarriage risk and are the only ways to definitively assess your baby's chromosomes. Approximately 99.6% of patients who have these procedures do not have a miscarriage.

By electing to receive an FTS you will receive FTS educational material. Please be advised that the information provided is not, nor is intended to be, a substitute for genetic counseling available from a physician-geneticist or genetic counselor.

At this time, it is unknown whether your health insurance company will pay for FTS. If your health insurer does not cover FTS, you may be responsible for payment. Accordingly, Hudson Valley Radiology Associates, P.L.L.C. reserves the right to bill and collect payment for the FTS following the provision of this service.

In addition to the fees for First Trimester Screening by Hudson Valley Radiology Associates, there is a laboratory fee from NTD Laboratories that may or may not be covered by your insurance. If you have any questions regarding that component of the overall fee, please contact (631) 425-0800.

Finally, our FTS credentialing process requires the accredited Maternal Fetal Imaging Specialist to document the outcome of your pregnancy. As part of this process, the accredited physician will need your permission to review the medical information concerning your pregnancy, to include all final diagnosis sheets for you and your newborn child. By signing this form, you agree to identify the hospital where you plan to deliver your child, and allow Hudson Valley Radiologist, or his authorized designee, to obtain all medical information for you and your newborn child. All information released to the accredited physician will remain confidential in accordance with all applicable state and federal patient privacy laws.

Patient Acknowledgment and Consent

By signing this First Trimester Screening Consent Form, I acknowledge that I have read this form in its entirety and been provided with an FTS Patient Education Brochure. If my insurance carrier does not cover this exam, I understand that I may receive a bill from HVRA for these services. I understand that I may also receive a separate bill from NTD Laboratories for the analysis of the blood work that is part of the First Trimester Screening program. I agree to be responsible for any charges that my insurance company may not pay and agree to pay this amount immediately upon receipt of a bill from HVRA in addition to any copay and deductible due on the OB Ultrasound.

By signing this form, I also agree to identify the hospital where I plan to deliver my child. At this time, I plan to deliver my child at _____(write in name of Hospital). I further agree that upon delivery of my newborn child, all medical information concerning my pregnancy, to include any final diagnosis sheet prepared for me and my newborn child, may be released to Hudson Valley Radiology, or their authorized designee. It is my understanding that any medical information obtained by Dr. Cohen or his authorized designee will remain confidential in accordance with all applicable state and federal patient privacy laws.

_____ _____

Patient's Signature Date

_____

Patient's Name