Call 1-877-BODY-CTS (1-877-263-9287) or make an appointment ONLINE

25 Boylston Street Suite L07
Chestnut Hill, MA 02467

CONSENT TO SERVICES AND RELEASE OF HEALTH INFORMATION WAIVER OF

LIABILITY FOR DIAGNOSIS, FURTHER TESTING AND TREATMENT

I, ___________________________________, am seeking radiological screening services from BeWell Body Scan, LLC ("BeWell") without a referral from my primary care physician or any other physician. By signing this Consent Form, I understand and agree to the following:

1. The services that BeWell will provide to me (the "BeWell Services") will be limited to the following:

   a. A computerized axial tomography (CAT) scan of my Lungs, Heart, Abdomen, and Pelvis. (The "Screening Test") performed by a radiology technologist and interpreted by a radiologist and/or a Virtual Colonography Screening Test performed by a radiology technologist and radiologist and interpreted by a radiologist.

      I understand that the following body parts: Head and Extremities; will not be included in any of the BeWell Services.

   b. A consultation with a BeWell radiologist during which the radiologist will describe to me the physical findings disclosed by the Screening Test. The radiologist will not provide a diagnosis of any disease or condition and will not recommend or provide any treatment.

   c. A written description of the results of the Screening Test and a copy of my Screening Test on CD-ROM will be delivered to me at the conclusion of the consultation.

2. I hereby consent to the performance of the BeWell Services for me. Prior to signing this Consent Form, a BeWell radiologist has provided me with information and discussed with me the benefits and risks of receiving the BeWell Services and the reliability and significance of any positive or negative findings from the Screening Test and/or the Virtual Colonography Screening Test. I understand that there is no guarantee that the Screening Test and/or the Virtual Colonography Screening Test will identify evidence of any particular disease or condition. I have been given the opportunity to ask questions about the BeWell Screening Services and the information that has been provided to me.

3. I understand and agree that BeWell will not be responsible for the diagnosis of any disease or condition based on the results of the Screening Test and/or the Virtual Colonography Screening Test, further testing or any plan of treatment based on the BeWell Services provided to me. I understand that it is my responsibility to provide the results of the Screening Test and/or the Virtual Colonography Screening Test to and to obtain diagnosis and treatment services from my primary care physician or other physician.

4. Please check one of the following:

_____ I **authorize** BeWell to send a copy of the written description of my test results to my physician:

Name: ____

Street Address: ____

City, State, Zip Code: ____

_____ I **do not** want a copy of the written description of my test results to be sent to my primary care or other physician. **I understand that BeWell strongly recommends that I authorize BeWell to send a copy of my test results to my primary care or other physician.**

5. I hereby release and hold harmless BeWell, its physicians, employees and agents from any liability, loss, settlement, claim, demand and/or expense of any kind (including but not limited to attorney's fees) arising from any claim that BeWell failed to diagnose any disease or condition, or failed to order or arrange further testing or a plan of treatment based on services provided by BeWell, or arising from any act or omission related to any diagnosis, further testing or plan of treatment subsequent to or based upon the BeWell Services provided for me.

6. I understand that BeWell Services are <u>not</u> covered by health insurers because they are provided without a referral for screening purposes, and not for the diagnosis or treatment of an illness or injury. I am responsible for payment for BeWell Services at the time BeWell Services are provided to me, and BeWell will not bill any insurer for these services.

7. BeWell will keep all information regarding the BeWell Services provided to me confidential pursuant to applicable federal and state law. Any disclosure of this information, other than to my Primary Care Physician or other designated physician (see #4 above), will require specific written permission from me.

8. BeWell may use my personal demographic information, to mail directly to me, any information regarding new services being offered at BeWell. I will not be contacted by BeWell for any fund raising activity.

Name of Patient: ____

Address: ____

City, State, Zip Code: ____

Telephone: ______________________________

E-mail: ______________________________

Date: ________________Signed: ____

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AUTHORIZATION FOR THE USE AND DISCLOSURE OF

HEALTH INFORMATION FOR RESEARCH

I, ____, hereby authorize BeWell Body Scan, LLC ("BeWell") and the B.I.H. Radiological Foundation to use the patient health information recorded by BeWell in connection with the computerized axial tomography (CAT) scan that will be performed for me (the "Personal Medical Data") to create a research data base. I understand that BeWell will record my Personal Medical Data in the research data base using a code identifier and will maintain the identification code separate from the data base so as to protect the confidentiality of my Personal Medical Data.

I further authorize the use of my Personal Medical Data by BeWell to conduct research studies for the purpose of assessing and improving the effectiveness of the Screening Test and an indicator and predictor of health status. I understand that this research will be performed using aggregated data from BeWell's research data base and that my Personal Medical Data will not be used or disclosed in any manner that would permit my Personal Medical Data to be identified with me. With my consent, BeWell Body Scan may call my home or other designated location or may e-mail my home or other designated location to assist in providing follow-up information and/or feedback relating to my BeWell visit.

This authorization will remain effective unless revoked by me. I understand that I have the right to revoke this authorization at any time by sending a written statement that I wish to revoke the authorization to BeWell at the following address:

BeWell Body Scan
25 Boylston Street
Chestnut Hill, MA 02467
Attention: Max P. Rosen, MD MPH (Medical Director)

The revocation will be effective on the date that it is received, except to the extent BeWell or the Foundation has used my Personal Medical Data to create aggregate data from which it cannot be separated.

Name of Patient: ____

Address: ____

City, State, Zip Code: ____

Telephone: ______________________________

E-mail: ______________________________

Date: ________________Signed: ____