BODYLOGIC™ SCAN CONSENT

USE

I consent to allow **West Florissant Internists** to use its DXA System to perform a body composition and/or bone densitometry scan, with full awareness that the technology uses low-dose x-rays. I understand the Hologic DXA system is a prescription device and is restricted by or on the order of a physician.

FINANCIAL RESPONSIBILITY

I accept financial responsibility for all charges for services provided to me and/or my family members.

WAIVER AND AGREEMENT

1. I do hereby release all representatives of **West Florissant Internists** that are acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in services, activities, or programs of **West Florissant Internists**.

2. I am voluntarily participating in the **West Florissant Internists** BodyLogic™ scan and I hereby agree to expressly assume any and all risks of injury and death.

3. I further hereby declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that disqualifies me from receiving a BodyLogic™ scan or any other service from West Florissant Internists I understand that **West Florissant Internists** is not acting as my treating physician and I acknowledge that I have permission to participate or that I have decided to participate in these services without the approval of my physician and do hereby assume all responsibility to take appropriate action with regard to test results.

4. I certify that I am not pregnant or trying to become pregnant.

5. Confidentiality. The information based on the observations made during any **West Florissant Internists** service and subsequent report is treated as privileged and confidential and will not be disclosed to health care providers or my employer.

I understand I have the right to receive a copy of this authorization by sending a written request to **West Florissant Internists**.

I have read the above and do consent to participate in the services rendered by **West Florissant Internists**.

_____ _____ _____

Client – Print your name

Client – Signature and date (mm/dd/yyyy)

bodyLOGIC™ The Science of Body Composition