

CONSENT FORM FOR ELECTIVE ULTRASOUND BY ROYAL BABY VISION 2D&3D/4D
STUDIO

I hereby authorize Royal Baby Vision to perform an elective 2D&3D/4D ultrasound on me and my baby in my preferred location. I understand that this ultrasound session is not performed for any medical reason, or to diagnose any medical condition. I understand that this service doesn't detect chromosomal, structural and obstetrical abnormalities but is provided only to provide photographic ultrasound images for family archival purposes and intertainment.

I agree that this ultrasound service is not covered by my insurance and will be paid by me at the time of service. I understand that during this service image quality may vary depending on baby's position, placenta location , amount of amniotic fluid and my size and weight. In the event that the picture is not of the desired quality, I agree that ROYAL BABY VISION does not guarantee to give me a good picture and that there will not be any refund for the service provided.

I am currently under a care of a physician and have had routine clinical appointments with my doctor, and will address all medical questions with my physician. I hereby waive and hold harmless the imager for any negligence in any form whatsoever.

I have read and understand the information in this document and that through my signature, I agree to all the terms stated.

Patient Signature:

Patient Name (printed):

Witness:

Date: