Foot & Ankle Center of Florida LLC
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Female Consent to Radiographic Imaging:

Patient Information:	
Name:	Date of Birth: Sex: ● Female

Consent for Diagnostic and or Minor Operative Procedure to be done:	
Initial Here Below	**Consent to the following:**
	I the patient named above do hereby authorize Frank Louis Lepore, DPM, MBA in the Foot & Ankle Center of Florida LLC and its associates or staff to perform upon me the above named patient the following diagnostic testing listed: **Radiographic X-rays.**
	Are You Sexually Active? ○ Yes ○ No
	Is there any chance that you are pregnant at this time? ○ Yes ○ No
	Despite risks to you or possibly to your unborn fetus(es) do you want an x-ray performed today to help with your diagnosis? ○ Yes ○ No
	Would like us to perform a pregnancy test on you today? ○ Yes ○ No
	I agree to have results of Pregnancy Test known to me? ○ Yes ○ No
	I understand that I will be charged a fee $35.00 to cover the pregnancy test to be performed on me today? ○ Yes I agree.
	I understand that this fee is in addition to my copay, deductible or patient responsibility that I owe and is also not included in the concierge plan to which I may be enrolled in with the Foot & Ankle Center of Florida LLC.
	I understand that Foot & Ankle Center of Florida LLC will try and bill the pregnancy test to my insurance by which I am covered and that I could be billed an additional fee to the $35.00 to cover the expense of providing a pregnancy test at this time if the insurance states so.
	Including photographing, videotaping, television or other observation of the procedures to be performed and may be purposeful for the advancement of medical knowledge and/or education or billing with the understanding that my patient's identity will remain anonymous. I also give permission to have any students or staff necessary to perform the procedure or to observe the procedure for their education.
	Frank Louis Lepore, DPM, MBA Has explained to me the nature and purpose of the procedure and has also inform me of the expected benefits and possible complications (from known and unknown causes) to me and my fetus(es), attendant discomforts and risk that may arise as well as possible alternatives to the proposed treatment including no treatment. I have been given an opportunity to ask questions and all my questions have been answered fully and satisfactorily and I have been given the opportunity to refuse.
	I acknowledge that no guarantees or assurances have been made to me concerning the diagnostic test by my doctor Frank Louis Lepore, DPM, MBA or the Foot & Ankle Center of Florida LLC and its associates or staff.
	I confirm that I have read and fully understand the foregoing and that all blank spaces have been completed prior to my signing. I've crossed out any paragraphs above which did not pertain to me.

Patient Signature/ Legal Guardian:	Date:
If Legal Guardian What is the relationship to the patient:	