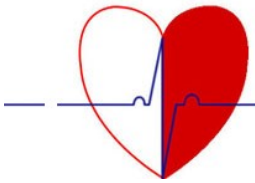

The Heartbeat Clinic

Amer Suleman M.D

MUGA (Multigated Acquisition Scan) Consent

Date of Test: _____ **Time:** _____

MUGA Instructions: You may eat and drink prior to the exam. Wear comfortable clothes and shoes. You may take your medications as normal. This exam will take approximately 2 hours. You will be able to drive afterwards (If you are able to drive yourself). Please call (214) 504-9942 if you have any questions regarding this procedure.

Consent for MUGA: I hereby authorize Dr. Amer Suleman to perform the MUGA. In order to determine an appropriate plan of medical management, I hereby do consent to voluntarily engaging in a MUGA with the injection of radioactive tracer to determine the function of my heart muscle in general. More specifically, it allows evaluating the contractibility of your heart. A special camera captures the events in the heart's pumping cycle: the contraction of the heart, followed by its relaxation. I understand the technologist will start an IV in the vein.

Female Patient Screening (applicable to females that are 11-55 years of age):

1. Is there any possibility you could be pregnant? Yes No
2. If "NO", please check appropriate:
   - ☐ Had a hysterectomy, tubal ligation, or post- menopausal?
   - ☐ Currently on birth control?
   - ☐ Your last menstrual cycle start within the last 14 days?

   When was the date of your last menstrual period _____
3. Are you currently breast feeding? Yes No

No Show Responsibility: The MUGA involves us ordering dye that must be opened before you arrive. If you do not show up for this appointment, the medication will be unusable. **Please give us 24-hour notice** if you will not be able to make the appointment. If you do not show up for this appointment and no notification is received within 24 hours prior to the test, then we will be billing you for the cost of the nuclear medication ordered. The total cost of medication is $190.00. Please let us know if you have any questions regarding this policy.

****PLEASE NOTE, IF YOU HAVE MEDICAID OR ANY MEDICAID MANAGED CARE PLAN, THEY WILL NOT COVER THE DRUG FOR THIS TEST AND YOU WILL BE RESPONSIBLE FOR PAY $190.00 FOR IT UP FRONT****

I have read and understand the above information. Patient Name: _____

_____	_____	_____
Patient Signature	Witness	Date