

THERMOGRAPHY FOR LIFE - PATIENT INFORMATION SHEET
ROI ROI+BREAST BREAST FULL BODY+BREAST UPPER BODY LOWER BODY

NAME _____ M/F AGE _____ DOB _____

ADDRESS _____ EXISTING / NEW PATIENT

CITY _____ STATE _____ ZIP _____

EMAIL _____ PHONE _____

Primary Physician _____ Referring Physician/Self Referred _____

OUR COMPUTER PROGRAM REQUIRES THAT EVERY QUESTION MUST BE ANSWERED FOR US TO PROCEED WITH YOUR SCAN.

Clinical Concerns/Issues (Why are you here / Clinical finding or particular diagnosis by your doctor)

Current Symptoms (patient feels or experiences)

Treatment: (Ex: Chiropractic, Acupuncture, Massage)

Medications:

of Thermograms You've Had: _____

Results of clinical correlation (Any clinical assessment that was done after the previous thermographic study)

Surgeries & Dates:

Dental: #Fillings _____ #Root Canal _____ #Crown _____ #Implant _____ Partial _____ Denture _____ Bridge _____

Gum Graphs _____ #Teeth Removed _____ Amalgams Removed _____ Other: _____

Your General History: (Past trauma, illness, disease or injuries)

Family History: (Mom/Dad/Grandparents/Siblings/Etc.)

Diagnoses (Any diagnosis of illness given to the patient by a medical practitioner)

Skin Lesions Or Physical Abnormalities & Location: (Ex Piercings, Tattoos, Scars, Skin Irritation, etc.)

Ob/ Gyn History (Anything related to the female genitourinary system)

#Mammogram _____ Date of Last Mammo _____ #Ultrasound _____ Date of Last Ultra _____

I understand that the Report generated from my images is intended for use by trained healthcare providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the images with respect only to the thermographic findings discussed in the Report. By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature of Patient or Patient's Authorized Representative Date: _____

Name _____ DOB ____/____/____

BREAST QUESTIONNAIRE - EVERY QUESTION MUST BE ANSWERED FOR US TO PROCEED WITH SCAN.

1. Do you have a close relative who had breast cancer? (Add under family history) _____ Yes No
2. Have you ever been diagnosed with breast cancer? (Circle) _____ Yes No
- Cancer Type:** Metastatic Local Lymph Node Involvement
- When diagnosed:** Month _____ Year _____
- Where (**Left Breast**) Upper Outer Upper Inner Lower Outer Lower Inner Nipple
- Where (**Right Breast**) Upper Outer Upper Inner Lower Outer Lower Inner Nipple
- Treatment:** Surgery Chemo Radiation Other None
3. Have you ever been diagnosed with any other breast disease? _____ Yes No
- Disease type:** Fibrocystic Cystic Mastitis Abscess Other (List other types in the general history on 1st page)
4. Have you had any biopsies or surgeries to your breasts? (Excluding cosmetic implant surgery) _____ Yes No
- Where (**Left Breast**) Upper Outer Upper Inner Lower Outer Lower Inner Nipple
- Where (**Right Breast**) Upper Outer Upper Inner Lower Outer Lower Inner Nipple
5. Have you had any breast cosmetic surgery or implants? _____ Yes No
6. Have you had a mammogram in the past 12 months? _____ Yes No
7. Have you had a mammogram in the past 5 years? _____ Yes No
8. Have you had abnormal results from any breast testing? _____ Yes No
9. Have you ever taken a contraceptive pill for more than 1 year? _____ Yes No
10. Have you suffered from uterine or ovarian cancer? _____ Yes No
11. Have you had pharmaceutical hormone replacement therapy? _____ Yes No
12. Do you have an annual physical breast examination by a doctor? _____ Yes No
13. Do you perform a monthly self breast exam? _____ Yes No
14. Did the patient's periods start before the age of 12? _____ Yes No
15. Did the patient's periods end after the age of 50? _____ Yes No
16. Had vaccination in past 4 weeks? Indicate which arm? (Circle) **Left arm** **Right arm** **None**
17. Total number of mammograms? _____ Numbers Only
18. Patient age at first mammogram? _____ Numbers Only
19. Number of children that patient has given birth to? _____ Numbers Only
20. What was the age of the patient at the birth of their first child? _____ Numbers Only
21. Does the patient smoke now or has ever smoked in the past?

Current Smoker Never Smoked Not in the last year Not in the last 5 years

22. Have you recently had any of these breast symptoms: (Circle)

Where (**Left Breast**) Pain Tenderness Lumps Change in breast size
Skin thickening or dimpling Secretions of the nipple

Where (**Right Breast**) Pain Tenderness Lumps Change in breast size
Skin thickening or dimpling Secretions of the nipple

PATIENT DISCLOSURE

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic findings discussed in the Report. By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature of Patient or Patient's Authorized Representative

Date

Thermography For Life

HIPPA - Authorization to Use or Disclose Protected Health Information

Patient: _____

Date of Birth: _____ **Date of Request:** _____

As required by the Privacy Regulations, *Thermography For Life* may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**
For the specific purpose of (describe in detail) **Interpretation of said images**

Effective dates for this authorization: ____/____/____ through ____/____/____ OR ____ **FOREVER**

Today's Date

Expiration Date

Initials

This authorization will expire at the end of the above period.

(Initial box)

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

REQUEST FOR ALTERNATIVE COMMUNICATIONS & PATIENT DISCLOSURE

I authorize Thermography For Life to email my thermography report and images to me at the email address I have provided above. This information is confidential. All information and email address I have provided is correct to my knowledge. I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic findings discussed in the Report. By signing below, I certify that I have read and understand the statements above and consent to the examination. The information provided during consultations, phone conversations, written communications, texts or on this website is intended for educational and informational purposes only. I am not a licensed medical doctor, and I do not diagnose, treat, cure, or prevent any disease or medical condition. Any discussion regarding natural supplements, nutrition, lifestyle practices, or wellness products should not be interpreted as medical advice, medical treatment, or a prescription. The information shared is based on general wellness education and personal or publicly available knowledge regarding natural health approaches. By choosing to receive this information, you acknowledge and agree that you are solely responsible for your health decisions and that you will consult with a qualified healthcare professional before starting any supplement, dietary change, or health program. You further agree that the practitioner is not liable for any adverse reactions, side effects, or consequences resulting from the use of any supplement, product, or health recommendation discussed. The statements regarding supplements or natural health products have not been evaluated by the Food and Drug Administration. These products are not intended to diagnose, treat, cure, or prevent any disease.

Signature of Patient or Patient's Authorized Representative

Date

Thermography For Life

352-346-2746

Patient Preparation Checklist for a Successful Thermal Exam

Your report will be emailed to you immediately as soon as it is interpreted by our medical doctor. You may print out the report or email it to your doctors of choice.

Purpose of the test:

Examination of the selected areas to detect recognizable signs of normal or abnormal physiological activity to determine if further clinical evaluation or preventive recommendations are required.

3 Months Prior:

- No major breast surgeries
- No minor breast surgery, i.e. biopsy
- No chemotherapy or radiation
- Cease lactation and breastfeeding

1 Week Prior:

- Avoid tanning or sunburn

24 Hours Prior:

- Avoid exercise, massage or chiropractic adjustment, no acupuncture or manipulation of body
- Refrain from steam room, sauna, hot or cold packs
- Avoid sitting in a hot tub
- Reschedule if you experience a significant fever

Day of Exam:

- Do not shave underarms
- Avoid using deodorant or creams on the area to be imaged
- Do not wear jewelry to exam – Exception: Rings that will not come off fingers.
- Wear hair on top of head – bring hair clips.

2 Hours Before Exam:

- Refrain from tobacco or coffee use (No caffeine)
- Avoid hot or cold liquids
- Refrain from exercise, bathing or showering
- Avoid eating or chewing gum if we are imaging your head and neck

PREPARATIONS ARE MY RESPONSIBILITY. I HAVE READ THE PREPARATION CHECKLIST AND HAVE FOLLOWED ALL OF THE DIRECTIONS.

Patient Signature

Date

Thermography For Life

(352) 346-2746

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Thermography For Life is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Thermography For Life." "It is our policy to provide a substitute health care provider, authorized by Thermography For Life to provide assessment and/or treatment to our patients, without advance notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment

Services are to be paid in full at time of service. *"As a courtesy to our patients, we will provide a receipt to you by email or text at the time of service. It is up to the patient to submit the receipt to your insurance carrier for the purpose of reimbursement for health care services rendered. The receipt contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

We may contact you for marketing purposes or fundraising purposes, as described below: (example)

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health

information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of *Thermography For Life* sponsored fund-raising events."

Change of Ownership

In the event that Thermography For Life is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Thermography For Life is not required to agree to the restriction that you requested. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request. You have the right to inspect and copy your health information. You have a right to request that Thermography For Life amend your protected health information. Please be advised, however, that Thermography For Life is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial. You have a right to receive an accounting of disclosures of your protected health information made by Thermography For Life. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Thermography For Life reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such an amendment is made, Thermography For Life is required by law to comply with this Notice. Thermography For Life is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Sherry Albert by calling this office at 352-346-2746. If Sherry Albert is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how Thermography For Life has handled your health information should be directed to Sherry Albert by calling this office at 352-346-2746. If Sherry Albert is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner, in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Thermography For Life with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

This notice is effective as of: ____/____/____ **(Today's Date)**

Patient's Name (print)

Date