Thermography Advantage

Authorization to Use and Disclose Protected Health Information

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: ____/____/_____ Phone _____ Email _____

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

I hereby authorize Thermography Advantage and any of its employees to use or disclose my Patient Health Information to the person(s), entity(s), or business associates of EMI, Electronic Medical Interpretations. Patient Health Information authorized to be disclosed: Thermal Images and related health history for the specific purpose of said images.

Your Thermogram Report will be emailed to the email that you provide here:

E-mail: _____

IMPORTANT: Reports will be sent from emireports@emi-interp.com. Be sure to check your JUNK/SPAM folder, as some mail service providers may flag it as spam.

If you would like to authorize for me to send a copy of your report to a physician, please list below the authorized party's name and location.

Authorized Party: _____

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____
Today's Date Date of your Choice

This authorization will expire at the end of the above period of your choice. You will be required to complete this form again with each appointment. 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 provide authorization to use or disclose protected health information.

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

Thermography Advantage

Digital Infrared Thermal Imaging Disclosure Form

Please read this form in its entirety.

X-rays, C.T.'s, Ultrasounds, and M.R.I.'s are all tests of "anatomy" that measure the structures of the body. Digital infrared thermal imaging (DITI) is unique in it's capability to show physiological changes and metabolic processes. It does not show structure.

DITI is used as an aid for diagnosis and prognosis, as well as monitoring therapy progress, for conditions and injuries. The images will be taken by a Certified Clinical Thermographer, and they will be interpreted by a Certified Doctor. The Certified Doctor, herein referred to as the Thermologist, reviews your images and provides a written report of his/her findings. Please see highlighted section of the HIPPA form to authorize how you prefer to receive your report. You may choose to have it mailed, or for a faster response, you may choose to have a PDF emailed to you of which you can make multiple copies.

It is very important to know that your first session provides the baseline of your "thermal signature", and that your likely recommended three month follow-up is used to assure that the patterns remain unchanged. Once your stable thermal pattern has been established, any changes can be detected during your routine annual studies.

It is also important that you know this test is radiation free and F.D.A. registered. It is not intended to replace mammograms or any other test or diagnostic procedure currently being recommended to you by your physician. Your Certified Clinical Thermographer taking your scans is not a doctor, and is unable to answer any medical questions you may have. Your images, however, will be reviewed by the Thermologist and will be available for interpretations by any physician of your choosing.

By signing this form I, _____(print name here), understand its contents and give consent to Thermography Advantage and its employees to take the above described images and send them for interpretation to EMI, Electronic Medical Interpretations.

Signature of Patient or Patient's Authorized Representative

_____

Date

_____

Name: _____ Birthdate:_____

Email: _____ Phone: _____ Doctor: _____

All information given in the questionnaire will remain strictly confidential and will only be divulged to Thermography Advantage and its employees, the reporting thermologist and anyone you otherwise specify.

Breast Thermography Confidential Questionnaire

	Yes	No
1. Do you have any close relative who has had breast cancer?	☐	☐
If yes, what relation? _____ Father's or Mother's side? _____		
2. Have you ever been diagnosed with breast cancer?	☐	☐
3. Have you ever been diagnosed with any other breast disease (fibrocystic)?	☐	☐
4. Have you had any biopsies or surgeries to your breasts?	☐	☐
5. Have you had any breast cosmetic surgery or implants?	☐	☐
If yes, saline or silicone? _____ Year of surgery _____		
6. Have you had a mammogram in the past 12 months?	☐	☐
7. Have you had a mammogram in the past 5 years?	☐	☐
8. Have you had abnormal results from any breast testing?	☐	☐
9. Have you ever taken a contraceptive pill for more than 1 year?	☐	☐
10. Have you ever been diagnosed with cancer of the womb?	☐	☐
11. Have you had pharmaceutical or bio-identical hormone replacement therapy?	☐	☐
12. Do you have an annual physical examination by a doctor?	☐	☐
13. Do you perform a monthly breast self exam?	☐	☐

How many mammograms have you had in total? (estimate) _____

What was your age when you had your first mammogram? (estimate) _____

How many births have you had? _____ Your age at birth of first child: _____

Did your periods start before the age of 12? _____ Or finish after the age of 50? _____

Do you smoke? Yes: ☐ Never: ☐ Not in last 12 months: ☐ Not in last 5 years: ☐

Check any RECENT symptoms that apply to each breast :	**Your Right Breast**	**Your Left Breast**
Pain	☐	☐
Tenderness	☐	☐
Lumps	☐	☐
Change in breast size	☐	☐
Areas of skin thickening or dimpling	☐	☐
Secretions of the nipple	☐	☐

Signature _____ Date_____

Thermography Advantage

Extended Breast Questionnaire For Breast Cancer or Biopsies

Patient Name: _____ Date:_____

If this page does not apply to me then initial _____

UO= Upper Outer UI= Upper Inner LO= Lower Outer LI= Lower Inner

Diagnosed with breast cancer:

Cancer type: Metastatic_☐_ Local_☐_ Lymph node involvement_☐_

When diagnosed: Month_____ Year_____

Where (your left breast): UO_☐_ UI_☐_ LO_☐_ LI_☐_ Nipple_☐_

Where (your right breast): UO_☐_ UI_☐_ LO_☐_ LI_☐_ Nipple_☐_

Treatment: Surgery_☐_ Chemo_☐_ Radiation_☐_ Other_☐_ None_☐_

Please list treatment details and dates on the next page.

Diagnosed with other breast disease:

Disease type: Fibrocystic_☐_ Cystic_☐_ Mastitis_☐_ Abscess_☐_ Other _☐_
(please report other types of disease in the history on the next page)

Breast biopsies or surgery:

Where (your left breast): UO_☐_ UI_☐_ LO_☐_ LI_☐_ Nipple_☐_

Where (your right breast): UO_☐_ UI_☐_ LO_☐_ LI_☐_ 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_____ Date_____

Thermography Advantage

Name: _____ D.O.B: _____ Age: _____

Occupation: _____

Emergency Contact: _____ Number: _____

Primary Care Physician: _____

How did you find us? (Please circle one) Friend Internet Physician Other_____

Current Symptoms:

_____

_____

_____

Current Treatment:
Are you or have you ever had lymphatic treatments? Yes or No (Please circle one)

_____

_____

_____

Current Medication:

_____

_____

_____

_____

Previous Surgeries / Include dates: (Please disregard if previously submitted)

_____

_____

_____

_____

Dental History: (Ex: Root canals, periodontal disease, crowns)
(Please disregard if previously submitted)

_____

_____

_____

_____

Initials_____

General Medical History: (Please disregard if previously submitted)

Skin Lesions or Physical Abnormalities: (Please disregard if previously submitted)

Significant Family History: (Please disregard if previously submitted)

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 to the thermographic findings discussed in the report. By signing above, I certify that I have read and understand the statements above and consent to the examination, and the information provided is accurate to the best of my knowledge.

Signature _____ Date _____

Client Contact Consent

By signing below you are giving permission to contact you by any telephone number or e-mail address associated with your account for the purpose of appointment reminders, in regard to services provided, or to collect monies owed. This permission extends to Thermography Advantage as well as any agents employed/associated with us.

Signature _____ Date _____