All About Herbs Thermal Imaging New Client Intake Form

Name: ______________________________

Date of Birth: ____________________ Age: ______

Street: ______________________________

Town, State, Zip: ______________________________

Phone Number: (   ) _____-______

How did you hear about us? ______________________________

____

Current Concerns or Symptoms:

____

____

____

Diagnosed medical problems: (high blood pressure, diabetes, arthritis, cancer, etc)

____

____

____

Infusion port or internal device? (Breast thermals will need to be rescheduled 90 days after port is removed)

____

Previous surgeries or Biopsies / Dates:

____

____

Current medications: (Prescriptions only)

____

____

____

____

Family History:

____

____

____

____

This information is confidential.
All information is correct and current to my knowledge.
No medical information has been intentionally been omitted for the purpose of this report.
Doctors need full disclosure to make an accurate reading.
Thermograms are not a replacement for mammograms.
Please call ***907-376-8327*** *if you have questions or need to reschedule.*

Signature: ______________________________ Date: ______________

Thermographer: ______________________________

Authorization to Use or Disclose Protected Health Information

All About Herbs

Patient Name:____

Address: ____

Date of Birth: ____________________ Date of Request:______________

As required by the Privacy Regulations, *All About Herbs* **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 _____/_____/_____
This authorization will expire at the end of the above period.

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.

____ ____________
Signature or Patient or Patient's Authorized Representative *Date*

____ ____________
Authorized Signature of Facility *Date*

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REQUEST FOR ALTERNATIVE COMMUNICATIONS

Patient Name:____
Address: ____
Date of Birth: __________________ Date of Request:____________

As allowed by the Privacy Regulations, I wish for this office to provide the following "Alternative" means of communicating my Protected Health Information:

☐ **Mailing Address.**
If appropriate, please contact me at the following address:

____

☐ **Phone.**
If appropriate, please contact me by telephone at the following number:

____

☐ **Fax.**
If appropriate, please contact me by fax at the following number:

____

☐ **E-Mail.**
If appropriate, please contact me by E-mail at the following E-mail address:

____

☐ **I have the following additional requests for confidential communications regarding my Protected Health Information:**
(Please explain)

____

____

I understand that there may be additional costs associated with this request and I agree to reimburse this office for such costs.

________________________________ _______________
Signature Date

☐ Accepted as requested. ☐ Modified as noted: ____________

________________________________ _______________
Authorized Signature of Facility Date

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All About Herbs
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.

All About Herbs 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

We only submit your health information to EMI for the sole purpose of interpreting you thermal scans.

We only submit your EMI Report to you at the mailing or email address you have provided.

We do not share your information with anyone else, unless we are required to do so by law.

Marketing and Contact.

As a courtesy we may contact you via telephone, text message or email to remind you of your appointment, or to remind you to make a follow up/annual appointment. We will not include any personal health information in these messages.

We will not use your information for any marketing, unless you request to be on our newsletter email list.

Change of Ownership.

In the event that **All About Herbs** 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 **All About Herbs** 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 **All About Herbs** amend your protected health information. Please be advised, however, that **All About Herbs** 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.

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- You have a right to receive an accounting of disclosures of your protected health information made by **All About Herbs.**

- 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

All About Herbs 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 amendment is made, **All About Herbs** is required by law to comply with this Notice.

All About Herbs 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: **Dawn Nelson** by calling the office at 907-376-8327. If **Dawn Nelson** 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 **All About Herbs** has handled your health information should be directed to **All About Herbs** by calling the office at 907-376-8327.
If **All About Herbs'** manager 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

This notice is effective as of ______/______/_______

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

By way of my signature, I provide **All About Herbs** with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

____
Patient's Name (print)

____ ____________
Patient's Signature Date

____ ____________
Authorized Facility Signature Date

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Breast Thermography Confidential Questionnaire

Name:____**Birthdate:**________________

Address:_______________________________**City:**______________________**Zip:**________

Email:_______________________________**Phone:**______________**Doctor:**______________

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

Please Mark Yes Or No As It Applies To You:	**Yes**	**No**
Do you have any close relative who has had breast cancer?		
Have you ever been diagnosed with breast cancer?		
Have you ever been diagnosed with any other breast disease (fibrocystic)?		
Have you had any biopsies or surgeries to your breasts?		
Have you had any breast cosmetic surgery or implants?		
Have you had a mammogram in the past 12 months?		
Have you had a mammogram in the past 5 years?		
Have you had abnormal results from any breast testing?		
Have you ever taken a contraceptive pill for more than a year?		
Have you suffered with cancer of the womb?		
Have you had pharmaceutical hormone replacement therapy?		
Do you have an annual physical examination by a doctor?		
Do you perform a monthly breast self exam?		

How many mammograms have you had in total? ___________
What was your age when you had your first mammogram?___________
How many births have you had?_______ Your age at the birth of your first child:_______
Did your period start before the age of 12?_______ Or finish after the age of 50?________
Do you smoke? Yes____ Never____ Not in the last 12 months____ Not in the last 5 years____
Had a vaccination in last 4 weeks? Indicate which arm: Left ___ Right ___ No ____

Breast Thermography Confidential Questionnaire

Have you **recently** had any of these breast symptoms?

Mark Right Breast or Left Breast as it applies	Right Breast	Left Breast
Pain		
Tenderness		
Lumps		
Change in breast size		
Areas of 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 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 ______________________________ Date ______________

THERMAL IMAGING IS:

·Non Invasive
·No Radiation is Emitted
·Painless
·FDA Cleared

Preparation for your scan is simple but critical to the accuracy of the results. Please be advised, failure to follow these simple guidelines will require us to reschedule your appointment and FEES WILL APPLY if we are unable to proceed with your originally scheduled time slot.

BEFORE THE APPOINTMENT:

·Fill out the required forms online

·Avoid strong sunlight exposure the day of, and sunburn in the days preceding your appointment

·No massage, chiropractic adjustments, acupuncture, physical therapy, infra-red saunas the day of your scan

·Avoid the application of creams, liniments, oils, or lotions, including but not limited to perfume and cologne

·No smoking for a minimum of 2 hours prior to your scan

·No vigorous exercise 2 hours prior to your scan.

·Remove all jewelry and earrings

·Long hair should be worn up

·It is very important to wear loose fitting clothing. The thermography scan will be delayed until irritation marks in the skin caused by tightly fitting garments have dissipated.

·Deodorant and light make up ARE permitted

AT THE CLINIC:

Arrive a few minutes early to your appointment. Your body will take some time to adjust to the temperature of the room. You will be given a cover to change into, as you will be disrobing down to your underwear. Speedo type undergarments or thongs are appropriate for both men and women. You will meet your thermographer who will explain and demonstrate the required views and positions necessary for your scan. Thermal images are then taken of either the whole body or just the regions of interest. Neurological testing can include a cold stress test which simply involves placing a hand or foot in a cool bowl of water or having a gel pad applied to any part of the body.

You are welcome to bring a friend, partner or spouse into the imaging room for the scan.